IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
OF FLORIDA IN AND FOR THE COUNTY OF MIAMI-DADE

FINAL REPORT
OF THE
MIAMI-DADE COUNTY GRAND JURY

SPRING TERM A.D. 2003

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State Attorney
KATHERINE FERNANDEZ RUNDLE

Chief Assistant State Attorney
DON L. HORN

Assistant State Attorney
BRONWYN C. MILLER

______________________	______________________
CONCEPCION PORTELA	**SHIRLEY BOYER**
FOREPERSON	**CLERK**

FILED
January 27, 2004

Circuit Judge Presiding
JUDITH L. KREEGER

Officers and Members of the Grand Jury

CONCEPCION PORTELA
Foreperson

DANIEL CALIXTE
Vice Foreperson

DONNIE K. JOHNSON
Treasurer

SHIRLEY BOYER
Clerk

JAIRO ABREU

LANA M. ANGEL

JOSE BELETTE

JULIAN BOWEN

HUMBERTO DURAN

LUIS C. GUIA

MILDRED M. KAVALIR

LIBBY KLEIN

FELIX M. LORENZO

JOSE L. MARCOS

DOROTHY MILLER

DARQUITA ROBINSON

JUAN F. RODRIGUEZ

GLORIA M. SARDUY

SANDRA M. SEGURA

ROYCE E. SMITH

MARTIN SUAREZ

* * * * * * *

Clerk of the Circuit Court
HARVEY RUVIN

* * * * * * *

Administrative Assistant
ROSE ANNE DARE

* * * * * * *

Bailiff
NELIDO GIL, JR.

I N D E X

INVESTIGATION INTO THE DEATH OF OMAR PAISLEY AND THE DEPARTMENTOF JUVENILE JUSTICE MIAMI-DADE REGIONAL JUVENILE DETENTION CENTER

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INVESTIGATION INTO THE DEATH OF OMAR PAISLEY AND THE DEPARTMENT OF JUVENILE JUSTICE MIAMI-DADE REGIONAL JUVENILE DETENTION CENTER

I. INTRODUCTION

Seventeen-year old Omar Paisley spent the last three days of his life, which ended June 9, 2003, in agony, lying on a concrete bed in Room 13 of Module Three in the Department of Juvenile Justice Miami-Dade Regional Juvenile Detention Center (hereinafter "MDRJDC"). Despite his repeated requests for help, Omar was denied that which many of us take for granted, appropriate and timely medical care.

As grand jurors, we came from different backgrounds, perspectives, and beliefs. However, in the course of our service, we discovered that we were united in our outrage over the death of Omar Paisley. All of us shared common values in our belief that juvenile detainees are entitled to live in safe, habitable, clean and secure surroundings. As parents, we knew that we were required to provide our children with medical attention or face the consequences. We felt strongly that when a facility assumes care for the children of our community, the facility should be held to this same standard.

We were sensitive to the implementation of severe budgetary cuts in our State following September 11, 2001. However, each of us arrived independently at the same conclusion: one can never measure the cost of human life in taxpayer money.

Over the past nine months, we listened closely and critically to testimony from various people involved in the investigation into the death of Omar Paisley, we labored over a multitude of statewide reports, we studied statistics and budgets, we toured both the MDRJDC and the Broward Regional Juvenile Detention Center and we asked questions at every step along the way. We were, above all, determined to make recommendations, which, if implemented, would prevent another unnecessary death in the MDRJDC.

We were appalled at the utter lack of humanity demonstrated by many of the detention workers charged with the safety and care of our youth. Our mission, constrained by our legally set time limit, included ascertaining the underlying causes that

led to this tragically preventable death in order to demand reforms, and if appropriate, concurrently identifying criminal acts that may have been committed, either by individuals or the facility administration or both. At every turn in our investigation, we were confronted with incompetence, ambivalence and negligence on the part of the administration and the staff of the MDRJDC as well as the nurses employed by Miami Children's Hospital. We discovered in the course of our investigation that numerous individuals played roles in the death of Omar Paisley. However, in determining which individuals should be charged with crimes, we are compelled to isolate only the most egregious conduct. In our estimation, the conduct of two of the nurses was so outrageous as to rise to the level of criminal negligence and we have felt compelled to issue indictments for these acts.

In the process, we became frustrated by the numerous legal and factual obstacles we were confronted with, especially with regard to pursuing criminal charges against the State, its facility and its direct employees.

The issues we confronted in this case were unique. We do not intend that our decision to issue indictments in this instance will open the floodgates to consideration of criminal charges in other cases that are purely civil in nature, i.e. medical malpractice. We are hopeful that the present state of the law regarding public entities, including administrative rules concerning government employees, does not diminish in any way the significance of our findings. Our findings clearly expose a lack of supervision, a lack of resources, and above all, a lack of benevolence in the MDRJDC.

Following are the conclusions we have thus far reached and the recommendations we most respectfully request be implemented. [1]

II. BACKGROUND REGARDING THE DEPARTMENT OF JUVENILE JUSTICE AND THE MDRJDC

In 1994, the Juvenile Justice Reform Act created a new state agency designed to oversee juvenile justice issues, the Department of Juvenile Justice.[2] The Secretary of the

[1] We recognize that, as in all cases, the facts and the evidence essential to the truth of a case surface as the case unfolds in the system over time. The law does not permit us to sit as a grand jury beyond nine months. We know this case will remain visible in the system for years to come. Those reforms that can occur today, must; however, those needs that become self-evident over time must also be addressed in the future.

Department of Juvenile Justice was charged with planning for and managing all programs and services in the juvenile justice system, including detention care.[3] In addition to creating the Department of Juvenile Justice, the Florida Legislature established the Florida Department of Juvenile Justice Quality Assurance System.[4] The purpose of the Quality Assurance System was to establish minimum thresholds for each component of programs operated by the Department of Juvenile Justice.[5]

In the State of Florida, there are a total of 25 juvenile detention centers with a total of 2,042 beds.[6] These centers serve three primary purposes: to detain and monitor juveniles prior to adjudicatory hearings; to maintain custody of all adjudicated juveniles awaiting placement in a commitment program; and to impose sanctions for mandatory sentences implemented pursuant to state law.[7] The MDRJDC is, by far, the largest in the State. The funded operating capacity of the center is 226 beds on any given day.[8] Between January 1, 2001 and December 31, 2002, 6,808 juveniles were booked into this facility, often exceeding the funded operating capacity.[9]

The facility is spread out over a large area of land and is comprised of fourteen modules intended to house the detainee population, a public school facility, a cafeteria, a medical center, a gymnasium and administrative areas. As with every juvenile detention facility in the State of Florida, the MDRJDC has a statutory duty to provide each juvenile detainee with food, clothing, shelter, education, and medical care. Historically, the Miami-Dade County Public Schools have provided education for the detainees and the facility has chosen to outsource medical care.[10]

In 2001, the MDRJDC entered into a contract with Jackson Memorial Hospital for the provision of medical services for all detainees. This contract was not renewed in 2002. Instead, on July 1, 2002, the facility opted to enter into a contract with Miami

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[2] Florida Corrections Commission, 2001 Annual Report at 5.
[3] Id.
[4] Florida Department of Juvenile Justice, Introduction to Quality Assurance revised March 24, 2003, 2.
[5] Id.
[6] www.djj.state.fl.us/detention/index.html at 1.
[7] Department of Juvenile Justice, 2003 Outcome Evaluation Report at 29.
[8] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 27, 2003.
[9] Id.
[10] Outsourcing refers to a process by which a State agency enters into a contract with a private entity to provide services required by statute.

Children's Hospital (hereinafter "MCH"). The Medical Services contract provided that the services of five MCH employees (two licensed practical nurses, one registered nurse, one physician and one file clerk) would be used to fulfill the medical needs of the detainees at the MDRJDC. The contract specified both hours and shifts: the registered nurse was to work forty hours per week (from 8:00 a.m. until 5:00 p.m. Monday through Friday); each licensed practical nurse was to work forty hours per week (with one working from 1:30 p.m. until 10:00 p.m. Sunday, Wednesday, Thursday, Friday and Saturday and the other working from 9:30 a.m. until 6:00 p.m. on Sunday, from 1:30 p.m. until 10:00 p.m., Monday and Tuesday and from 7:00 a.m. until 3:30 p.m. Friday and Saturday); the physician was to work nine hours per week; the file clerk was to work forty hours per week (from 8:30 a.m. to 5:00 p.m., Monday through Friday).

During the same month that MCH entered into the contract to provide medical services with the MDRJDC, the State of Florida Bureau of Quality Assurance conducted its 2002 annual inspection.[11] Findings issued in the 2002 Bureau of Quality Assurance Report indicated that the MDRJDC was *non-compliant* with statewide facility standards and rated its overall program performance as *minimal*.[12] Specifically, the report found that the facility was non-compliant with required substance abuse assessment and evaluation for detainees, screening for health-related conditions, appropriate inventories of controlled substances, implementation of a required system for control of infectious, communicable diseases, and implementation of a required system for the provision of sick call care.[13]

As reported, surveyed detainees indicated that they did not see the doctor or dentist in a "timely manner."[14] The inspection also revealed a persistent failure to obtain consent from parents prior to administering mind-altering medications to the detainees and failure to educate staff as to the side effects of those medications. Detainees complained of not being provided with clean towels, clean underwear or clean clothing as required pursuant to departmental policy.

[11] The report itself was issued in September, 2002.
[12] The contract between MCH and the Department of Juvenile Justice began on July 1, 2002.
[13] See Department of Juvenile Justice, Bureau of Quality Assurance Report (2002).
[14] Id. at 7.15 (page 21). It should be noted that a "timely manner" was not defined in the body of the report.

III. BACKGROUND REGARDING OMAR PAISLEY

Over eight months after the release of the abysmal 2002 Bureau of Quality Assurance Report, seventeen-year old Omar Paisley was arrested by the Miami-Dade Police Department on charges of aggravated battery. Omar was evaluated pursuant to a Department of Juvenile Justice Detention Risk Assessment form to determine whether or not he should be detained in the MDRJDC pending the resolution of his case. A Department of Juvenile Justice Risk Assessment Tool recommended commitment in secure detention and the presiding judge ordered Omar Paisley detained in the Department of Juvenile Justice MDRJDC.

On March 26, 2003, the State subsequently filed an announcement of its intent to review the case for direct file pursuant to section 985.21(4)(d)5, Florida Statutes (2003). Following this filing, Omar's defense counsel contacted the State in an effort to convince the State to retain the case in the juvenile system. Omar Paisley wrote a letter to the State Attorney's Office stating: "I am sorry for what I have done. I made a stupid mistake. I was wrong. I should not have had a fight with that man." On June 6, 2003, Omar Paisley entered into a written plea agreement wherein he admitted to committing the offense of aggravated battery and agreed to enter into Bay Point Schools, a "moderate risk" residential program, where he would also receive individual counseling. Omar was to remain in secure detention at the MDRJDC pending his placement in the residential program.[15]

Day One: *Saturday*

On Saturday morning, June 7, 2003, less than twenty-four hours after he entered into his plea, Omar Paisley began to complain of illness to both staff members and his fellow detainees. Omar filled out a "Youth Request for Sick Call" form. These forms were in use in the facility for detainees to communicate medical complaints to the Department of Juvenile Justice staff members.[16] Once the form is submitted to a Department of Juvenile Justice Staff member, notification of the "Request" is sent to the Medical Station. Omar wrote on his form: "My stomach hurts really bad. I don't know

[15] The Plea Agreement was filed on June 6, 2003. The plea agreement specified that a psychiatric examination was a prerequisite for program placement.

what to do. I cand (sic) sleep." He signed the bottom of the form and gave it to a Juvenile Detention Officer (hereinafter "JDO"). Logbook entries reveal that the Medical Station was notified at 12:10 p.m.[17] Omar refused to eat lunch on Saturday.

At approximately 2:15 p.m., according to an entry in the Module Three logbook, a Licensed Practical Nurse (hereinafter "LPN") by the name of Gaile Loperfido saw Omar.[18] This is the first contemporaneously documented visit of LPN Loperfido.[19] LPN Loperfido filed an addendum to Omar Paisley's medical records the day after he died. Her addendum indicates that she first saw Omar at 9:00 a.m. on Saturday morning. However, we found no evidence to corroborate the 9 o'clock morning visit.[20] LPN Loperfido's addendum also indicates that she conducted a physical examination of Omar on Saturday. Detention staff members contend that they never saw LPN Loperfido conduct a physical examination of Omar that day.[21] In fact, these staff members did not observe LPN Loperfido carrying any equipment with which to conduct a physical examination, i.e. a blood pressure cuff or a thermometer.[22]

After seeing Omar at approximately 2:15 p.m., LPN Loperfido filled out a twenty-four hour medical alert form, specifying that Omar's medical alert would end on Sunday, June 8, 2003. She placed Omar on a twenty-four hour liquid diet and ordered him on bed rest.[23] LPN Loperfido's addendum further indicates that she saw Omar at 7:00 p.m. on Saturday. However, this visit is not corroborated by logbook entries, nor is it consistent with the testimony of the Department of Juvenile Justice staff.[24]

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[16]Miami Children's Hospital, Sick Call and Injury Response Procedures.

[17] A logbook is maintained in each of the modules at the facility and is used to record all entries into the module and any action taken as to any detainee. According to a June 7, 2003 entry in the Module Three logbook: "Detainee Paisley, Omar complaining about being sick. He refused to eat lunch. Nurses station notified." (12:10 p.m.)

[18] It should be noted that LPN Loperfido has twenty-five years experience as a medical professional.

[19] Her addendum further sets forth that she first saw Omar at 9:00 a.m. on Saturday morning and documents a series of visits over Saturday and Sunday, totaling 5 visits. The logbooks do not reveal prior documented visits.

[20] See Sworn Statements of JDO Keith North and JDO Nesby Rodriguez.

[21] Id.

[22] Id.

[23] The twenty-four hour liquid diet was in direct contravention with the Miami Children's Hospital Sick Call and Emergency Response Procedures. These procedures reflect the following for "Abdominal Discomfort:" (i) give nothing by mouth; (ii) consult with on-call medical provider; (iii) refer to E.R. if acute abdomen is suspected.

[24] See Sworn Statements of JDO Johnny Byrd and JDO Kavin Walton.

At 3:45 p.m. on the same day, Dr. Lloyd Miller arrived to perform Omar's psychiatric examination pursuant to the plea agreement. Dr. Miller noted that Omar was an average sized young man who was under the sheets of his bed suffering from gastroenteritis. He discovered that Omar was on bed rest which is why Dr. Miller made a house call "to the bedside of this young man who appeared not to be in one hundred percent perfect health."[25] He further observed that Omar "was sick with a stomach virus and his physical condition may have affected his mental outlook during the interview."[26] The MCH physician did not work on Saturday, June 7, 2003, and he was not contacted by LPN Loperfido regarding Omar's condition on that day.

On Friday, the day before these events transpired in Module Three, another detainee was complaining of similar symptoms in Module Seven. He submitted a Youth Request for Sick Call Form and the Medical Station was notified. According to the medical records of that detainee and the June 6, 2003 logbook entries, that detainee was seen by LPN Dianne Demeritte. After meeting with that detainee, LPN Demeritte referred the detainee to the physician. The detainee was indeed physically examined by the physician and later transferred to the emergency room.[27]

Day Two: *Sunday*

On Sunday, June 8, 2003, witnesses reported that Omar continued to complain of abdominal pain, and continued to have vomiting and diarrhea.[28] LPN Loperfido saw Omar at approximately 9:00 a.m. on Sunday.[29] LPN Loperfido continued to order a liquid diet and bed rest, as she had the preceding day. As LPNs are traditionally charged with patient assessment, a major issue in this case is whether or not LPN Loperfido conducted a physical examination of Omar during the Sunday morning visit.[30] Detention

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[25] Dr. Miller received information from the detention staff on duty and Omar regarding Omar's condition.
[26] Id.
[27] See Medical Records of D.H. (it should be noted that juvenile detainees are referred to by initials only).
[28] See Sworn Statement of JDO Michael Johnson at page 25 (Omar told LPN Loperfido his stomach was "so sore").
[29] The Logbook reflects a 9:05 a.m. visit by LPN Loperfido. "Nurse on mod to see Paisley, Omar. Youth has a virus and complaining of serious abdominal pain. Staff advised to give plenty of liquid and not to allow youth to leave room." Again, LPN Loperfido's addendum to Omar's medical records indicates that she first saw Omar at **9:00 a.m.** on Saturday morning and documents a series of five visits over Saturday and Sunday. We do not have any evidence to corroborate these **five visits.**
[30] It should be noted that a medical diagnosis (as opposed to a nursing diagnosis) is typically done by a physician.

staff contend that they did not observe her perform a physical examination.[31] Per her addendum, LPN Loperfido states that she again saw Omar on Sunday night at approximately 8:00 p.m. However, detention staff members contend that she went to Module Three to see another detainee, A.W., but did not see Omar.[32] The MCH physician was not working on Sunday, June 8, 2003, and LPN Loperfido did not contact him regarding Omar's condition on that day.

Day Three: *Monday*

According to sworn statements of JDOs and an entry in the Module Three Logbook, on Monday, June 9, 2003, Omar woke up at 5:30 a.m. urgently requesting medical care. The on-duty JDO observed: "Paisley is not looking real well."[33] Per JDOs Burney and Morgan, this message was conveyed to the Department of Juvenile Justice LPN at breakfast. However, there was no apparent follow-up.[34]

By most accounts, Omar spent Monday in excruciating pain.[35] He was unable to get out of the bed and continued vomiting and excreting on himself.[36] Payroll records indicate that at least four of the five contracted MCH medical personnel were working in some capacity at the facility on that day. However, by all accounts, it appears that only LPN Dianne Demeritte saw Omar on Monday.[37]

At approximately 1:32 p.m., Indigo[38] JDO Alfreda Mitchell picked up detainee K.R. on Module Three. Upon arrival on Module Three, Officer Mitchell was informed of Omar's chronic illness by a JDO. Officer Mitchell returned to the Medical Station with K.R. and believes she informed LPN Demeritte at that time of Omar's worsening condition.[39]

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[31] See Sworn Statements of JDO Shana Jerry and JDO Michael Johnson.
[32] See Sworn Statements of JDO Johnny Byrd and JDO Kavin Walton.
[33] Entry in Module Three Logbook at 9:05 a.m.
[34] The Department of Juvenile Justice LPN was in a training during the day on June 9, 2003.
[35] See Sworn Statement of JDO Johnny Byrd at 21; Sworn Statement of JDO Michael Johnson at 30.
[36] See Sworn Statement of A.W. at 22; See Sworn Statement of Terry Mixon.
[37] Detainee S.S. stated that LPN Demeritte saw Omar once before dinner and once after dinner. LPN Demeritte indicated to the Department of Juvenile Justice LPN that she had seen Omar twice on the date of his death. See Sworn Statement of LPN Jeffrey Coachman to Office of the Inspector General at 20.
[38] An "Indigo" JDO is an officer who is assigned to escort medical personnel throughout the facility.
[39] See Sworn Statement of Alfreda Mitchell to the Office of the Inspector General at 7.

Detention Officer Terry Mixon was alone on Module Three with over twenty detainees for much of the afternoon and early evening hours of June 9, 2003.[40] At dinner, between 5:30 p.m. and 5:50 p.m., Officer Mixon saw LPN Demeritte in person and asked her to check on Omar.[41] Officer Mixon appeared worried and told LPN Demeritte that Omar was "real sick," already on a liquid diet and could not keep anything in his stomach.[42] He told LPN Demeritte that someone needed to look at Omar.[43] Sworn statements reveal that during the early evening hours, Officer Mixon contacted Indigo Officer Talmecia Minnis two times over the radio in an effort to summon LPN Demeritte.[44] Officer Minnis conveyed these requests to LPN Demeritte.[45]

Immediately after dinner, and upon Mixon's return to Module Three, numerous officers heard Officer Mixon frantically requesting assistance over the radio from a nurse or a supervisor.[46] These calls continued for an hour and a half, but there was no immediate response.[47] Although Officer Mixon could see Omar's worsening condition, he could not leave the module to get assistance nor could he call 911 to summon help for Omar. As to the former, he was the only JDO in the module and he could not leave more than twenty detainees unattended. As to the latter, the design of the telephone system within the facility prevents anyone from being able to make 911 emergency phone calls from inside the modules. Further, to do so without first contacting a supervisor or making the request through Central Control[48] with approval of a supervisor could constitute a violation of procedure and could subject Officer Mixon to disciplinary action.

Officer Mixon made radio contact with LPN Demeritte via Indigo JDO Minnis sometime prior to 7:00 p.m.[49] According to Officer Mixon, LPN Demeritte asked what

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[40] Entry in Module Three Logbook at 181.
[41] Id. at 8.
[42] Id. at 6.
[43] Id.
[44] Sworn Statement of Talmecia Minnis to Office of the Inspector General at 8.
[45] Id. at 9.
[46] See Sworn Statement of JDO Johnny Byrd at 21.
[47] Id.
[48] Central Control is located directly inside the front entrance of the facility. All incoming and outgoing telephone calls, visitors, employees, mail, and deliveries are directed through Central Control.
[49] See Sworn Statement of JDO Terry Mixon at 9. See Sworn Statement of Indigo JDO Talmecia Minnis to Office of the Inspector General at 8.

was wrong with Omar and indicated she was busy with other things.[50] Officer Minnis recalled that LPN Demeritte indicated several times via radio she would respond to Module Three, but did not respond.[51] A witness indicates that LPN Demeritte was not in a particular hurry that night; rather, she had time to carry on conversations with staff and sit down on the various modules for a period of time.[52] LPN Demeritte indicated during the course of one conversation with Officer Mixon that she did not wish to examine Omar due to the fact that she had a sick child at home.[53]

Sometime after 8:00 p.m., LPN Demeritte finally made her way to Module Three to look at Omar. Per Officer Mixon and the detainees housed in Module Three, despite the fact that Omar could barely move, LPN Demeritte ordered Omar out of his cell.[54] Omar dragged himself out of his cell, clinging to a chair outside the door for support.[55] LPN Demeritte stated that she had a child at home and did not wish to contaminate her child with Omar's virus.[56]

Cellular telephone records reflect that at 8:08 p.m., LPN Demeritte contacted her supervisor, Registered Nurse (hereinafter "RN") Stacy Linfors.[57] According to detainees, LPN Demeritte was laughing on the telephone during the less than two-minute conversation. At 8:30 p.m., LPN Demeritte completed the paperwork authorizing Omar to be transferred to Jackson Memorial Hospital for emergency treatment. On the transfer paperwork, LPN Demeritte indicated that Omar had a 98.5 temperature and a normal pulse. LPN Demeritte handed the transfer paperwork to Central Control, told the Central Control JDO that Omar had a normal temperature but was delusional, and then left the facility without coordinating rescue efforts.[58]

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[50] Id.
[51] Id.
[52] Id. at 33.
[53] See Supplemental Sworn Statement of JDO Terry Mixon.
[54] Id.
[55] Id.
[56] Id.
[57] The duration of the telephone call was 118 seconds. Based on the information we received, this was the first contact anyone made with the RN regarding Omar. There is no evidence that has been presented to us that indicates that the MCH physician was ever notified of Omar's condition before Omar's death.
[58] This failure to coordinate emergency efforts is discussed at length later in this report.

As she was leaving the facility, LPN Demeritte was contacted by JDO Aileru regarding an ill detainee, I.E., on Module Eight. LPN Demeritte was told that I.E. was vomiting, had diarrhea, and needed to be seen by medical personnel. LPN Demeritte stated that the detainee should fill out a Medical Request for Sick Call form and proceeded to leave the facility.[59] Her decision to leave was in direct contravention of the Miami Children's Hospital/Department of Juvenile Justice Contract for Medical Services.[60]

After LPN Demeritte prepared the paperwork authorizing Omar's transfer for emergency treatment, detention staff initially made efforts to transport Omar to Jackson Memorial Hospital with the MDRJDC van and equipment. However, Facility Operating Procedures required Omar to be placed in leg and arm restraints (even though in this instance the detainee could barely walk). Because Omar was unmoving and catatonic by the time rescue efforts were initiated, lengthy discussion was had regarding the best means for transport. Omar continued to sit in the chair outside of his cell on Module Three. As he remained in the chair, brown fluid flowed from his nose and mouth.

Eddie Williams, a volunteer for the Christian Counseling Program, visited the facility that evening to counsel several of the juvenile detainees. Mr. Williams proceeded to Module Three at approximately 9:00 p.m. He described what he saw when he arrived as: "fear, panic, grief, [and] anger."[61] Mr. Williams observed Omar slumped over in the chair outside of Room 13. He immediately checked and noted that Omar had no pulse. Despite the fact that each detention worker was trained in First Aid and Cardiopulmonary Resuscitation, not one of them engaged in efforts to save Omar's life. LPN Demeritte was nowhere to be found at this time.

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[59] See Sworn Statement of JDO Ayodele Aileru at 5.

[60] The Miami Children's Hospital/Department of Juvenile Justice contract specifies that licensed practical nurses "shall provide the following services: coordinate any emergency medical or dental care approved by the facility superintendent or designee." It further specifies: "nursing services shall provide consultation and response to medical crises, by either on-site presence or coordination of care throughout local emergency care facilities." (emphasis added).

[61] Sworn Statement of Reverend Eddie Williams at 4.

At 9:01 p.m., approximately forty-five minutes after LPN Demeritte's conversation with RN Linfors, a call was finally placed to 911.[62] At 9:12 p.m., almost an hour after LPN Demeritte ordered emergency transport and left the facility, paramedics arrived on Module Three and found Omar unresponsive. Omar was transported to Jackson Memorial Hospital, where he was declared dead on arrival at 9:43 p.m.

Sometime that evening, JDO Terry Mixon was instructed by his supervisor to make delayed entries in the Module Three logbook detailing LPN Demeritte's interaction with Omar Paisley. He made an entry in the logbook documenting LPN Demeritte's appearance on Module Three.

The MCH physician was contacted for the first time regarding Omar Paisley between 10:30 p.m. and 11:00 p.m. on Monday, June 9, 2003.

On Tuesday, June 10, 2003, LPN Loperfido submitted a detailed "Addendum to Medical Records," documenting her treatment of Omar Paisley on Sunday, June 8, 2003. That same day, LPN Demeritte told the Department of Juvenile Justice LPN that she did not want to go in Omar's room the preceding day because she didn't want to catch his virus and take it home.[63] She further indicated that she had seen Omar twice the preceding day.[64] She indicated that during her second visit to Module Three, Omar had been delusional.[65]

IV. *ISSUES REGARDING EMERGENCY PROCEDURES IN THE MIAMI-DADE REGIONAL JUVENILE DETENTION CENTER*

When we first immersed ourselves into the facts surrounding the death of Omar Paisley, each of us listened to the recording of the call placed by Department of Juvenile Justice staff to 911 on the evening of June 9, 2003, with feelings of anger, sorrow, and confusion. Over forty-five minutes elapsed between the time LPN Demeritte issued orders for Omar to be transported to the hospital and the time a call was placed to 911.

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[62] We were unable to determine why such a long period of time passed before a call was made to 911. It should be noted that Central Control initially contacted 911 at 9:01 p.m., but the call was disconnected prior to any conversation. Several seconds later, a second call was placed. In the communications with the 911 operator, the caller indicated that: "the nurse has left the compound."

[63] See Sworn Statement of LPN Jeffrey Coachman to Office of the Inspector General at 17.

[64] Id.

[65] Id.

We listened as a caller told a 911 operator that Omar had a normal pulse and normal breathing pattern at 9:06 p.m., consistent with the paperwork filled out by LPN Demeritte. We knew, based on testimony, that by this time, Omar had no pulse, was not breathing, and had brown fluid seeping from his nose and mouth.

Armed with this information, we carefully watched the first round of Legislative Hearings pertaining to the death of Omar Paisley. In the course of these hearings, we scrutinized the testimony of Larry Lumpee, Assistant Secretary of the Department of Juvenile Justice. Mr. Lumpee stated that each detention officer was capable of dialing 911 directly from any given facility in the event of an emergency. The Facility Operating Procedures in place in the MDRJDC indicate to the contrary.[66]

We were further dismayed when we toured the MDRJDC and visited the modules. We discovered that when we attempted to dial 911 ourselves, the telephones located in each module did not permit direct access to 911. Instead, workers are required to contact a shift supervisor and then 911 calls are approved and routed through Central Control. We further learned that secure detention workers are not permitted to utilize personal cellular telephones in the facility.

Finally, we heard compelling testimony regarding the fear of detention workers to defy their chain of command and to reach out to outside agencies. We learned of specific instructions communicated by the Superintendent of the Facility to staff members prohibiting them from contacting external agencies without specific prior Superintendent approval.[67] Thus, we concluded that the legislative testimony of Mr. Lumpee failed to accurately portray the reality of the situation at the MDRJDC.

For comparison purposes, we decided to visit the Broward Regional Juvenile Detention Center (hereinafter "BRJDC"). When we toured the BRJDC, we noted that a different system for contacting 911 was in use. Specifically, each room populated by detainees, staff, or both, had an intercom on the wall that could be pressed to instantly connect with Central Control. Engaging the intercom in this manner instantly allowed

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[66] We were aware that Miami-Dade Regional Juvenile Detention Center Facility Operating Procedure 7.13 requires that 911 be " . . .called by the shift supervisor as needed."

Central Control to view the room via a surveillance camera and to assess the situation. It also permitted verbal contact via the intercom.

We were disturbed at the looming potential for both staff and detainee emergencies in MDRJDC. We firmly believe that emergency situations require emergency measures. We observed first-hand the efficiency of the system implemented in the BRJDC. We tested it and determined it was the best means of insuring direct, immediate contact with Central Control, and thus with 911. We further believe that each staff member should have *direct* access to 911 from all areas of the facility populated by detainees or staff.

We recommend that the MDRJDC immediately install an intercom system comparable to the system currently in place in the BRJDC. As an immediate alternative during the installation process of the intercom system, we recommend that the current Facility Operating Procedures be modified immediately to provide for any employee noting an emergency situation to have unimpeded direct access to 911. This would require Facility Operating Procedures to reflect that any employee who perceives an emergency situation, must, as a matter of responsibility, call 911. This responsibility should, in our opinion, exist separate and apart from the mandates assigned to any medical personnel. Further, as a practical measure, we believe that a telephone system must be implemented in the facility in which each area populated by detainees is equipped with direct access to 911. Finally, we recommend that current Facility Operating Procedures be re-written to require detention workers to first contact 911 in an emergency situation, and only then to contact Central Control.

We recommend that procedures be implemented requiring that on those occasions when medical personnel order emergency transport, either Central Control or detention workers are required to contact 911 within one minute. This should not be problematic, given either the implementation of direct access to 911 from each module or the installation of an intercom allowing for direct contact with Central Control. Together, we believe that when a human being is suffering and a life hangs

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[67] We learned of an altercation that occurred between two detention workers. An external law enforcement agency was contacted by staff following the altercation. The Superintendent of the facility became angry and notified the staff members that all incidents should be handled within the facility.

in the balance, the decision to call 911 should be immediate and without contemplation.

V. OVERCROWDING IN THE FACILITY

We were amazed to learn that many Department of Juvenile Justice secure detention facilities in the State of Florida are populated beyond the recommended capacity. Statewide, ten of twenty-five detention centers operated above one hundred percent capacity during 2001-2002.[68] In Miami-Dade County, the Regional Juvenile Detention Center had an average utilization rate of one hundred and thirty-five percent in 2001-2002.[69] Thus, despite the fact that the operating capacity of the facility was 226 detainees, the average daily population was 304 detainees.[70]

The obvious result of this overpopulation is overcrowding and shared quarters. The less obvious result is the staffing shortages we observed firsthand. Overcrowding renders detention difficult to manage and not as safe for residents and staff as a facility operating at recommended capacity.[71] Residents spend more time in lockdown. When staff members "must focus primarily on safety and security, effective intervention and treatment are compromised."[72] Staffing shortages may result in suicidal detainees being left unattended for significant time periods and may increase escape attempts. In the MDRJDC, specifically, the overcrowding has resulted in such problems as the failure to provide one operable shower for every nine youths, as required pursuant to Quality Assurance Standards.[73]

While we heard testimony, provided during the Legislative Public Hearings that overcrowding could be attributed to increased stays in secure detention, we were aware of

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[68] Detention Services, 2003 Outcome Evaluation Report at 31.
[69] Id. We did note that in Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 23, 2003, the average population was stated to be 251 during 2002-2003.
[70] Id.
[71] JAIBG Bulletin at 3. In the course of our investigation, we learned of an incident that occurred on February 11, 2003 in which a Guardian Ad Litem attorney visited a detainee at the MDRJDC. When the attorney arrived at the facility, the JDO on the detainee's module *did not have a key to open the detainee's cell*. It took approximately ten minutes for the JDO to retrieve the key that matched that cell from elsewhere in the facility. The attorney, rightfully, was deeply concerned regarding the ability of the staff to release the inmate in an expeditious manner in a fire or emergency situation.
[72] Id.
[73] Department of Juvenile Justice, Bureau of Quality Assurance Report (2002), 3.03 (page 9).

the fact that statewide, the average stay in secure detention in 2001-2002 was 13.04 days. This number reflected a *decrease* from the average length of stay in 2000-2001 of 13.27 days. In Miami-Dade County, the decrease was greater. The average length of stay in secure detention from 2001-2002 was 15.04 days, while from 2002-2003, it was 14.91 days.[74]

Despite the persistent issue of overcrowding in the facility, the MDRJDC does not have a contingency plan for overcrowding/group arrest. In facilities in which such a plan exists, operating procedures define critical population levels and set forth counteractive measures. Further, allowances may be made for detainees to be transported to a nearby facility in situations of severe overcrowding.[75] In the BRJDC, a "Contingency Plan for Overcrowding/Group Arrest" is carefully delineated within the Facility Operating Procedures.[76] Specifically, the plan sets forth that whenever the population in the facility exceeds the available bed space, the superintendent or designee will perform, at a minimum, the following actions: (1) notify the Southern Regional Office, Human Service program administrator, juvenile court judges, court unit, Office of the Public Defender, and Office of the State Attorney; (2) if the population issue persists, notify the Regional Director, Assistant Secretary of Programs, and the Deputy Secretary of Operations; (3) call in staff to work overtime at a ratio of one staff per ten detainees exceeding the recommended number of detainees; (4) review the capacity of home detention; and (5) request expedited placement from commitment managers.[77]

While we are aware of the waiting periods associated with entry into many residential programs, we are confident that increased efficiency regarding the performance by medical staff of physicals, mental health assessments, and the coordination of transportation efforts will decrease the length of time that detainees spend awaiting entry into these programs.

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[74] 2003 Outcome Evaluation Report at 32; Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 23, 2003.
[75] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 27, 2003.
[76] Broward Regional Juvenile Detention Center Facility Operating Procedures, Contingency Plan for Overcrowding/Group Arrest No. 49 (Revised 1/15/02).
[77] Id.

We recommend that the MDRJDC immediately implement a contingency plan for overcrowding/group arrest. We further recommend that such a plan include a designated overflow facility. The implementation of such a plan will prevent detainees from having to share quarters, will ensure that detainees are provided with adequate services, and will allay safety and security concerns.

A. MODULE STAFFING ISSUES IN THE FACILITY

For most of the afternoon on the day of Omar's death, there was only one detention officer on Module Three. Records from the facility indicate that there were twenty-eight detainees on the module that day.[78] This created a situation in which the officer knew that Omar desperately needed medical care, but could not leave the module either to procure medical assistance or to take Omar to the medical station. This further presented a safety risk to both the staff member and the detainees.

We noted that many facilities around the country require written policies dictating a minimum staff-detainee ratio. The most commonly implemented policy requires the governance and supervision of multiple detainees on a twenty-four hour basis by a minimum of *two* employees, with an overall staff ratio of eight to one during waking hours and sixteen to one during sleeping hours.[79]

In the State of Florida, recommended mandatory ratios between detainees and staff exist in confinement programs, but were eliminated by the legislature in secure detention facilities.[80]

We recommend the implementation of mandatory detainee-staff ratios. We recommend that each module be staffed by no less than two staff members at all times, with an overall staff ratio of eight to one during waking hours and sixteen to one during sleeping hours. We recommend that the Superintendent of the Facility bear personal responsibility for signing off on schedules to ensure that employees comply with this ratio.

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[78] See Department of Juvenile Justice MDRJDC Detainee Log.
[79] Wyoming Juvenile Justice Study at 5.
[80] See Florida Department of Juvenile Justice Policies and Procedures (specifying a recommended minimal staff to offender ratio of 1:5).

B. <u>CENTRAL CONTROL STAFFING IN THE FACILITY</u>

While on our tour of the MDRJDC, we observed firsthand that the Central Control booth was overwhelmed with activity. Central Control handles all incoming calls; all equipment deliveries; all visitation requests; all outgoing 911 calls; coordination of all transportation requests; and the constant monitoring of surveillance cameras installed throughout the facility. In addition, various workers arriving at or leaving the facility go through Central Control. Thus, we were stunned to learn that the MDRJDC does not have a requirement for minimum staffing in Central Control. On the evening that Omar Paisley died, there was only one employee working in the Central Control area. Since, ideally, working closed-circuit television cameras reflecting different areas of the facility would be monitored by staff in Central Control, a single worker simply cannot perform the tasks required of this position.

We recommend that the facility implement a policy requiring a minimum of two workers at all times be assigned to Central Control. One worker should be specifically assigned to monitor the facility via the surveillance system and one worker should be specifically assigned to address all other duties in Central Control.

VI. *LACK OF A FUNCTIONING SURVEILLANCE SYSTEM IN THE FACILITY*

During our investigation, we longed for a dispassionate, objective recording of the days preceding Omar Paisley's death. We longed for documentation to verify or dispel the many complaints lodged by detainees about physical and verbal abuse at the hands of detention workers. However, we learned in the course of our investigation that although cameras were installed in the MDRJDC nearly ten years ago, most were not working at the time of Omar's death. Those that did work allowed only for real-time monitoring, as opposed to videotaping which would allow one to playback and review what was recorded by the camera. Inter-departmental e-mail correspondence indicates that staff had begun complaining about the failure of the system as far back as 1997.[81] In 1998, e-mail correspondence indicated that the "recording equipment is now obsolete-- rendering it difficult to fix. The warranty was no good due to incorrect relocation of the equipment."

In 2000, two incidents emphasized the continuing failure of the surveillance system in the facility. On July 25, 2000, an employee in the facility was reported to the Office of the Inspector General for allegations of striking a detainee repeatedly and excessively with a broomstick.[82] The employee was investigated, the allegations were substantiated, and a report was issued. The report contained findings that "the Dade RJDC Management failed to ensure the video equipment was operating correctly which prevented review of this incident."[83] A second, identical incident was documented in a parallel report, issued on August 30, 2000.[84] Again, the investigative report findings, released on April 3, 2001, contained the provision, "it is substantiated the Dade RJDC Management failed to ensure the video equipment was operating correctly which prevented review of this incident."[85]

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[81] This is reflected in e-mail correspondence dated June 20, 2003 between Department of Juvenile Justice Regional Detention Chief Karen Cann and Assistant Secretary Larry Lumpee: "[staff] began complaining about the breakdown in signals to monitors and recording devices in 1997."
[82] This incident is documented in Department of Juvenile Justice Office of the Inspector General Case Number 00-05258.
[83] Id. at 5.
[84] This incident is documented in Department of Juvenile Justice Office of the Inspector General Case Number 00-06081.
[85] Id. at 5.

On June 20, 2003, Department of Juvenile Justice Regional Detention Chief Karen Cann sent an e-mail to Assistant Secretary Larry Lumpee indicating that the cameras in the facility were faulty at the time of the death of Omar Paisley: "it has been reported that a playback system was not included in the design, and the recording system did not identify which cameras were being recorded."

While we understand that the existence of working surveillance cameras and videotaping equipment at the MDRJDC might not have saved the life of Omar Paisley, we are mindful of the fact that it could have helped us tremendously during our investigation. For instance, it might have definitively revealed whether or not Omar received physical examinations during LPN Loperfido's Saturday and Sunday visits. It might have also resolved the conflict regarding the number of visits she made to Omar's cell on those two days.

We questioned administrators during our tour of the facility in an effort to determine whether or not this situation had been remedied, but were met with conflicting information. Further, we examined testimony adduced from detainees during the course of the first Legislative Public Hearing in this case regarding physical abuse in confinement cells. We were disheartened to learn that repairing surveillance equipment has not been a priority in past budgetary requests.

We collectively determined that a surveillance system is essential in a facility of this type in order to ensure the safety of both the juveniles housed in the facility and the detention workers employed by the facility. We noted that this would immediately solve most disputes investigated by the Office of the Inspector General, as no longer would these investigators be forced to make a credibility determination between a detention worker and a detainee.

We recommend that the existing surveillance system be replaced immediately with a system that will allow for recording in each area of the facility. We further recommend that an inspection be implemented at the beginning of each shift to ensure that the surveillance system is working. We recommend that the Superintendent and Assistant Superintendents of the facility bear personal responsibility for confirming at the beginning of each shift that the surveillance system is working.

VII. ***PROVISION OF MEDICAL CARE IN THE FACILITY***

A. ***MEDICAL REQUEST FORM RESPONSE TIME***

When we began to explore the specifics of Omar's death, we were met with the reality that the provision of medical care within the MDRJDC was, historically, untimely and inconsistent. In September of 2002: "there [was] no obvious method for tracking youth with chronic health issues and needs [and] laboratory utilization [had] been reduced."[86] The Department of Juvenile Justice Support Services Division documented their concern in an electronic communication to the superintendent of the detention center: "[support services] audited health services (sixteen records) and [MCH] still have (sic) eighty-five plus physicals not done. Physicals are not being done within the twenty-one day time period, immunization records are not on the charts, consents are not on the chart, and the required health education is not being done, etc. . . ."[87] Further communications between Department of Juvenile Justice Support Services and MDRJDC revealed a flawed tracking system: "[support systems] was especially concerned when the R.N. [said] that she doesn't make medical files on all detainees and has no tracking mechanism for those who are short stays (three days or less) . . . The excessive backlog of physicals, lack of health educations, etc. . . are of great concern. They definitely need to make better use of their physician/nursing staff time and start to make some impact on the backlog."[88]

A follow-up visit to the facility in January of 2003 by the Support Services Division revealed "active" files without current physical examinations.[89] The explanation provided was that records had been misfiled.[90] The visit further revealed that

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[86] Department of Juvenile Justice MDRJDC, Memorandum re: Quarterly Monitoring Visit dated September 23, 2002 at 1.
[87] Electronic mail from Department of Juvenile Justice Support Services to the Superintendent of the MDRJDC dated September 18, 2002 at 11:39 a.m.
[88] Electronic mail from Department of Juvenile Justice Support Services to the Department of Juvenile Justice Southern Regional Office dated September 18, 2002 at 12:00 p.m.
[89] Department of Juvenile Justice MDRJDC, Memorandum re: Follow-up to Corrective Action Monitoring Visit dated January 14, 2003 at 1.
[90] Id.

physicals were being completed in a time span of sixty to ninety days, as opposed to the twenty-one days specified by policy and procedure.[91]

A surprise visit by Detention Services in February of 2003 revealed "one hundred and thirteen active files with various incomplete forms within the active file. Eighty files were on the shelf awaiting physical examinations."[92] The visit further revealed " . . . inventories have not been maintained on the Modified Class II Pharmacy Stock as well as the OTC [over the counter] stock." The response by the RN to this observation was that " . . . it would be difficult to get all the nurses to comply with the inventory service."[93]

The only mandated health care response time that exists within the "Sick Call and Emergency Response Procedures" is the following: "Sick call follow up referrals must be evaluated within seventy-two hours of dated request."[94] We noted that there did not appear to be compliance with a recommendation forwarded as early as September of 2002, urging that "the medical department needs to develop tracking mechanisms, and to establish controls to meet deadlines for physicals and recall for chronic health conditions."[95] When we requested statistical information from the Department of Juvenile Justice regarding the average response time of medical staff in addressing youth complaints, we learned that this data is not collected.[96]

The seventy-two hour response time clearly does not take into account the potential for emergency or serious medical situations. Further, as there are medical personnel on duty every day in the facility, we thought the existing response period was much too long. In attempting to construct a more practical response time, we were painfully aware of the futile efforts of one detention worker to obtain assistance on the evening of Omar's death. We were also affected by Omar's own pleas for a nurse or doctor on the morning and throughout the day of his death.

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[91] Id.
[92] Department of Juvenile Justice MDRJDC, Memorandum re: Monthly Site Visit dated March 4, 2003 at 1.
[93] Id.
[94] Miami Children's Hospital, Sick Call and Injury Response Procedures IV(f).
[95] Department of Juvenile Justice MDRJDC, Memorandum re: Quarterly Monitoring Visit dated September 23, 2002 at 2 and 3.
[96] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 27, 2003.

We noted that nationwide, many facilities have designated mandatory response times for "health-related situations." This type of protocol abolishes the need for a medical judgment call by Department of Juvenile Justice staff. We were particularly impressed with Standards in the State of Washington, which require staff and other personnel to respond to health-related situations within a four-minute response time.[97]

We recommend that health care requests be addressed on the same day they are issued. We further recommend that all detainees complaining of illness undergo complete physical examinations by medical personnel. These physicals should always include vital signs and blood work when necessary.

B. LACK OF FACILITY OPERATING PROCEDURES GOVERNING HEALTH CARE REQUESTS

The Miami Children's Hospital "Sick Call and Emergency Response Procedures" in place in the facility allows for detainees to fill out medical request forms when they are ill. It should be noted that this procedure *has not* been incorporated into the Department of Juvenile Justice Facility Operating Procedures to ensure the mandatory documentation of medical complaints by Department of Juvenile Justice Staff. Thus, the looming potential for miscommunication between health care workers and detention staff, as illustrated by the Omar Paisley case, is ever present.

We recommend the immediate implementation of Facility Operating Procedures to address appropriate procedures governing medical request forms. These Procedures should include a requirement that detention staff members first provide ill detainees with medical request forms, collect said forms, and forward said forms immediately to medical personnel.

C. ISSUES RELATING TO MEDICAL STAFF IN THE FACILITY

1. LACK OF A HEALTH SERVICES IN-HOUSE DELIVERY SYSTEM

Our investigation in this case revealed that prior to the death of Omar Paisley, various issues relating to the supervision and outsourcing of medical staff had been brought to light by the Commission on Corrections. In fact, we specifically noted that a

[97] Facility Operating Procedures in Washington State at 13.

prior recommendation to in-source medical care had been made as long ago as in early 2001: "The Department of Juvenile Justice should develop a Health Services delivery system whereby all health-related personnel and services report directly to the Chief Medical Officer. In developing this system, the Department of Juvenile Justice should consult with the Department of Corrections and the Correctional Medical Authority."[98]

With the exception of one LPN, whose duties are generally limited to assisting with routine physical examinations and dispensing medication, the Department of Juvenile Justice does not directly employ medical personnel.[99] Rather, each facility enters into a contract with a private entity to ensure the provision of medical care. This outsourcing allows for the great potential for a communication failure between medical personnel and facility administration. Although the medical provider is required to sign off on all Facility Operating Procedures and educate staff as to the relevant provisions, the lack of compliance with these procedures is evident and is discussed in detail in subsequent sections.

We further noted that this combination of in-house medical personnel and outsourcing allows for a lack of communication between the LPN employed directly by the Department of Juvenile Justice and the medical personnel contracted with MCH. Specifically, on the date of Omar's death, the Department of Juvenile Justice LPN was notified of Omar's chronic illness in the cafeteria in the early morning hours. There is no indication that the Department of Juvenile Justice LPN notified any of the medical staff from Miami Children's Hospital of this issue.[100]

Disturbingly, we noted that there is no chain of command in the MDRJDC by which medical personnel must report to *anyone* from the Department of Juvenile Justice subsequent to arriving at the facility or prior to departing the facility. There is, quite simply, no in-house system in place to monitor the working hours of medical

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[98] Review of the Florida Department of Juvenile Justice (draft 11/9/01 at 46).
[99] It should be noted that the salary of the Department of Juvenile Justice LPN was significantly lower than the salaries of the LPNs employed by Miami Children's Hospital and assigned to the MDRJDC. See Contract between Miami Children's Hospital and Department of Juvenile Justice MDRJDC; Department of Juvenile Justice, Response to Subpoena Duces Tecum dated November 7, 2003.
[100] See note 34, supra and accompanying text.

personnel.[101] There is no system of supervision to assure that medical personnel are using their time to render treatment to detainees. There is no effective communication regarding required treatment of detainees.

We agree with the Commission on Corrections and recommend that the Department of Juvenile Justice consult with the Department of Corrections and make every effort to build an in-house health services staff designed to provide comprehensive medical, dental, and mental health services for male and female detainees throughout the facility. This should include health education, preventative care, and chronic illness treatment plans at the minimum community standard of care.[102] We further recommend that the Department of Juvenile Justice designate a single Chief Medical Officer to oversee the medical care in each detention facility.

2. FAILURE BY MEDICAL STAFF TO RESPOND TO REQUESTS FOR ASSISTANCE AND FAILURE BY MEDICAL STAFF TO COORDINATE EMERGENCY EFFORTS

The lack of supervision of medical staff by MDRJDC administration manifested itself in the failure of medical staff to respond to requests by staff for assistance and, ultimately, the failure by medical staff to coordinate emergency efforts on the evening of the death of Omar Paisley.

On the date of Omar's death, Monday, June 9, 2003, LPN Demeritte was assigned to work from 1:30 p.m. to 10:00 p.m.[103] Beginning in the early afternoon, detention officers began requesting assistance for Omar. LPN Demeritte failed to respond to these repeated requests for assistance until approximately 8:00 p.m. After she finally arrived to assess Omar, LPN Demeritte ordered emergency transport, but then *left the facility prior to coordinating this care* and well before the end of her shift. During the course of our investigation, we discovered that LPN Demeritte indicated on her time card for June 9, 2003 that she had worked from 9:30 a.m. to 10:00 p.m.

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[101] Although medical personnel must certify their working hours to Miami Children's Hospital, we discovered, at least in the case of LPN Demeritte, that the certification does not necessarily reflect actual hours worked. See, also Section C-2 infra.

[102] See http://www.dc.state.fl.us/employ/health/index.html.

[103] Contract between Miami Children's Hospital and Department of Juvenile Justice MDRJDC at 12.

We believe that LPN Demeritte's abrupt departure from the facility prior to coordinating rescue efforts curtailed the prompt delivery of lifesaving efforts. Further, her departure from the facility prior to the arrival of emergency medical services eliminated the possibility that medics would have an accurate medical assessment of Omar's condition.

It is imperative that health care workers from the hospital inform a designated Department of Juvenile Justice Assistant Superintendent prior to leaving the facility during an unscheduled time period. It is also essential that a system exist whereby the Department of Juvenile Justice is able to monitor any deviation from contractual provisions, either in the form of failing to comply with standing orders or failing to comply with hourly requirements.

Until the in-house provision of medical care is finalized, we recommend the immediate implementation of a system whereby medical staff are required to report to Department of Juvenile Justice MDRJDC administration upon their arrival at the facility and prior to departing from the facility. We further recommend that Department of Juvenile Justice MDRJDC administration be responsible for certifying the hours worked by medical staff. Finally, we recommend the implementation of immediate, personal sanctions by a contracting medical entity for the failure by medical staff to coordinate emergency efforts.

3. FAILURE BY NURSING STAFF TO CONTACT A PHYSICIAN AND FAILURE BY MEDICAL STAFF TO FOLLOW STANDING ORDERS

The contract between MCH and the Department of Juvenile Justice required that final medical judgments regarding the health care of a detainee must rest with a single designated physician.[104] However, we noted that in reality, detainees are fully dependent upon the medical judgment of nurses. In the case of Omar Paisley, there is no indication that the physician was ever even informed of Omar's condition by any of the nurses until

[104] The contract specifically states: "the physician is responsible for care of the treatment of common, non-emergency illnesses and injuries." It further adds: "[nurses are to] review medical intake forms with the physician and consult with the physician on specified youth's needs."

after his death.[105] We observed further that these nurses failed to comply with the standing orders issued by the MCH physician in conjunction with the MRJDC.[106]

We recommend that a physician be required to review in a timely manner the chart of each and every detainee rendered treatment by nursing staff. We recommend that this review include an analysis of follow-up treatment rendered and compliance with standing orders.

4. FAILURE BY MEDICAL STAFF TO DOCUMENT MEDICAL RECORDS IN A COMPREHENSIVE AND TIMELY MANNER

The Bureau of Quality Assurance Standards issued by the State of Florida dictates "all sick call encounters provided by the licensed healthcare professional will be documented in the chronological progress notes of the healthcare record and on the sick call index."[107] The standard further mandates "all findings should be recorded at the time of the health encounter."[108]

The Facility Operating Procedures implemented in the MDRJDC reiterate this principal: "on-site sick call care, including the administration of over-the-counter medication by unlicensed staff members and care administered by licensed health care professionals and health care paraprofessionals must be legibly documented in ink. Such documentation must be made in the Chronological Progress Notes in the Individual Health Care Records and [include] (1) date and time of the sick call encounter; (2) the detainee's sick call complaint; (3) the findings of the person rendering sick call care; (4) treatment rendered; (5) education and instructions given to the detainee; (6) plans for future treatment or follow-up, if any; (7) need to notify parents/guardians; and (8) signature of staff member rendering care."[109] The purpose of these guidelines is clearly

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[105] It should be noted that LPN Loperfido specified in *her own handwriting* on the only medical paperwork she placed in Omar's file prior to his death that his twenty-four hour medical alert was to end on June 9, 2003. Only detainees with active "Youth Request for Sick Call" forms and twenty-four hour medical alerts are referred *automatically* to the physician.

[106] As previously stated, the Miami Children's Hospital Sick Call and Emergency Response Procedures delineated a specific requirement for treating "Abdominal Discomfort:" (i) give nothing by mouth; (ii) consult with on-call medical provider; (iii) refer to E.R. if acute abdomen is suspected."

[107] Bureau of Quality Assurance Standards, No. 7.15.

[108] Id. at No. 7.20.

[109] Department of Juvenile Justice MDRJDC Facility Operating Procedure 7.15 revised January, 2003 at 3.

communicated: "[d]ocumentation . . . provided by a licensed health care professional . . . [must] communicate pertinent information to other health care professionals."[110]

Health care staff in the facility has had a history of not documenting the administration of medication. During one Inspector General investigation concerning the failure by staff to document the distribution of medication, one member of the medical team stated in November of 2001, " . . . the practice is to simply give over the counter medications to [detainees] and not record it on a form."[111] This failure to document was not limited to those detainees suffering from physical ailments; it was rampant in the files of detainees residing in the mental health specialty units. On January 14, 2003, Department of Juvenile Justice Detention Services observed "[t]here was concern about the lack of timely documentation on the detainees residing in the mental health specialty units. The "crisis unit" psychiatrist came in today and documented *three months* worth of progress notes and orders with backdates (emphasis added)."[112]

When we reviewed the medical files of other detainees housed in the Miami-Dade Regional Detention Facility, we realized that this failure to document medical treatment was commonplace. On Friday, June 6, 2003, the Module Three Logbook reflected an altercation between two detainees.[113] An entry in the logbook indicated that one of the detainees had been physically injured and had been referred for appropriate medical treatment.[114] A review of the medical file of the detainee failed to reveal what treatment medical staff had administered to the detainee.[115] Three days later, on Monday, June 9, 2003, the Module Three Logbook reflected that a detainee was complaining of stomach pains.[116] The medical file for this detainee does not reflect treatment.[117] Further, this particular detainee was taking psychotropic medication and there is no indication as to his

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[110] Id.
[111] This quote is contained within Department of Juvenile Justice Office of the Inspector Report for Case Number: 01-06647.
[112] Department of Juvenile Justice Memorandum dated January 14, 2003, Follow-up to Corrective Action Monitoring Visit.
[113] Module Three Logbook entry dated June 6, 2003 at 4:30 p.m. regarding C.S.: "Detainee [C.S.] seeks medical attention."
[114] Id.
[115] See Department of Juvenile Justice Medical Records for detainee C.S.
[116] Module Three Logbook entry dated June 9, 2003 at 8:15 a.m. regarding D.D.: "[Detainee, D.D., complaining of stomach pains."
[117] See Department of Juvenile Justice Medical Records for detainee D.D.

dosage or his progress on the medication.[118] Later on that same day, medical records reveal that yet another detainee had been taken to the medical station.[119] However, the "Tracking Tool for Nurses"[120] failed to reflect contact with the detainee. We noted that this inconsistency in documentation ensures miscommunication between medical staff.

We concluded that LPN Loperfido failed to comply with required documentation procedures when she treated Omar Paisley on Saturday, June 7, 2003 and Sunday, June 8, 2003. Her recorded impressions of Omar for Saturday, June 7, 2003 were incomplete. She did not record any impressions of Omar at all from Sunday, June 8, 2003 until the day after his death. She did not make a notation of medication administered, which could have potentially impacted Omar's symptoms or placed him at risk of over-medication by a subsequent staff member.[121] The combination of these failures further prevented the commencement of a chart review on Monday, June 9, 2003, by other nursing personnel or the physician.

Similarly, we concluded that LPN Demeritte also failed to comply with the above detailed provisions when she treated Omar Paisley on Monday, June 9, 2003. She did not record any visits to Omar during the day on June 9, 2003. She did not record observations, medication administered, or any other critical information. She did not contemporaneously record accurate vital signs, as her documentation regarding Omar's condition at 8:30 p.m. is medically impossible and contradicted by eyewitnesses.

We recommend that health care workers who fail to document medical records, progress notes, the administration of medication, and follow-up treatment in an accurate and timely manner be subject to immediate, harsh sanctions.

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[118] Id.

[119] See Department of Juvenile Justice Medical Records of K.R.

[120] The "Tracking Tool for Nurses" is an internal tracking device utilized by MCH/MDRJDC to maintain a record of which detainees were treated by nurses on any given day.

[121] It should be noted that Omar's name did not appear anywhere on the Medication Administration Records for the relevant time period.

5. ASSIGNING AN OFFICER PERMANENTLY TO THE MEDICAL STATION / REQUIRING THAT ALL PATIENTS BE EXAMINED IN THE MEDICAL STATION OF THE FACILITY

During our visit to the MDRJDC, we noted that although a written policy delineated where a patient would be examined or treated, most officers were unfamiliar with the policy.[122] Further, there is no indication that medical personnel comply with the policy.[123] The natural result of this is a system in which detainees were consistently waiting for medical staff to visit a module, but no means existed to track the medical staff. Thus, patients were not treated in a timely fashion.

When we visited the BRJDC, we immediately noted that the Medical Station was staffed at all times by a detention officer. We further noted that a policy existed mandating that all detainees be examined and/or treated by the medical staff in the Medical Station. As a result, sick calls were handled in a timely, efficient, and orderly manner.

We believe that the Broward system has obvious merit. We therefore recommend that this system be implemented in Miami-Dade County. After filling out a Youth Request for Sick Call, each youth should be accompanied to the Medical Center by a Detention Officer. The youth should then wait in the center until a health care worker is available. In the event that a detainee is too ill to walk, serious consideration should be given for immediate emergency transport at that time.

6. LACK OF AVAILABILITY OF 24-HOUR ON SITE MEDICAL CARE IN THE FACILITY

When we initially delved into the facts surrounding Omar's death, we learned that Omar had complained of severe pain throughout the very early morning hours on the date of his death. At that time, there were no medical personnel on duty. However, later the same morning no fewer than three nurses and one doctor were on duty *at the same time*.

We were at a loss as to why there would be consistent overlap in staff and no provisions in place to allow for twenty-four hour medical care. We noted that

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[122] The Sick Call and Injury Response Procedures differentiate between "Clinic Sick Call" (during office hours) and "Unit Sick Call" (after hours or during medication rounds).

nationwide, there is a trend in larger detention facilities to provide a full medical clinic with both general and psychiatric services available twenty-four hours per day.[124] It was very simple for us to envision scenarios in which twenty-four hour medical care could mean the difference between life and death.

Based upon the size of the MDRJDC, we recommend the immediate implementation of twenty-four hour on-site medical care for all detainees.

VIII. RELATIONSHIP BETWEEN THE DEPARTMENT OF JUVENILE JUSTICE AND THE OFFICE OF THE INSPECTOR GENERAL

The Office of the Inspector General of the Department of Juvenile Justice provides auditing, investigative, management advisory and background screening services for the Florida Department of Juvenile Justice.[125] The duties of the Department of Juvenile Justice Office of the Inspector General are prescribed pursuant to section 20.055, Florida Statutes.[126] There are approximately eight Inspector Specialists from the Department of Juvenile Justice Office of the Inspector General responsible for conducting investigations at over two hundred and twenty facilities in the State of Florida.[127] The investigations conducted by these specialists involve everything from allegations of sexual harassment and employment discrimination to allegations of physical abuse.[128]

We noted that many criticisms have arisen regarding the chain of command of the Department of Juvenile Justice Office of the Inspector General and the final outcome of past investigations into incidents in juvenile detention facilities. As a result, we carefully and critically examined the structure of the existing complaint system and made several determinations.

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[123] On Monday morning, Omar requested a nurse. There is no indication that a nurse saw him during the morning medication rounds. See Sworn Statement of JDO Troy Morgan.
[124] Juvenile Detention Standards in Washington State, at 21.
[125] http://www.djj.state.fl.us/agency/inspectorgeneral.
[126] Id.
[127] At the time of the writing of this report, there were two vacant positions of Inspector Specialists within the Office of the Inspector General of the Department of Juvenile Justice.
[128] We noted that the Inspector Specialists staff an employee hotline. However, we noted that this hotline appeared to be both underpublicized and underutilized, as policy violations were rampant in the Miami-Dade Regional Secure Detention Center.

Typically, Department of Juvenile Justice Inspector Specialists are notified of an incident and have a prescribed time period in which to conduct a thorough investigation into the incident. Ultimately, the findings of the Department of Juvenile Justice Inspector Specialist are forwarded to the Inspector General of the Department of Juvenile Justice for a final determination as to whether or not a complaint is substantiated or unsubstantiated. The Department of Juvenile Justice Inspector General, in turn, reports the results of the investigation to the Secretary of the Department of Juvenile Justice. The Department of Juvenile Justice will determine what action, if any, should be taken in any given case. However, this decision is made *without input* from the Department of Juvenile Justice Inspector Specialist assigned to the case.

The Inspector General of the Department of Juvenile Justice and his or her Inspector Specialists are "at-will" employees, meaning they serve in "selected exempt service" at the pleasure, ultimately, of the Secretary of the Department of Juvenile Justice. They do not report to the Chief Inspector General of the State of Florida. Despite their desire to maintain the integrity of the investigations they undertake, Inspector Specialists are not immune to the pressure to maintain their employment by projecting a positive image of the Department of Juvenile Justice. Conceivably, the same may be said of the Inspector General of the Department of Juvenile Justice.

We recommend that the Department of Juvenile Justice Office of the Inspector General report directly to the Chief Inspector General of the State of Florida in order to ensure the neutrality and the integrity of all investigations. We further recommend that the Department of Juvenile Justice receive input from the assigned Inspector Specialist in making disciplinary determinations as the result of any given investigation.

IX. ISSUES RELATING TO STAFFING AND SUPERVISION

A. FAILURE TO CONDUCT PRELIMINARY NATIONAL BACKGROUND SCREENINGS ON PRIVATELY CONTRACTED PROVIDERS

We all agreed that the skills and qualifications required of juvenile detention officers are oftentimes greater than those necessary in a jail or prison setting. We

recognized that detainees are uniquely reliant upon Department of Juvenile Justice workers and privately contracted agencies for their health and safety. We thought it was particularly important for juvenile detention workers to serve as positive role models for the troubled youth housed in secure detention. As a result, we were disturbed by many departmental practices that appeared to result in the hiring and retention of unqualified and incompetent staff.[129]

As mentioned previously in the course of this report, each individual detention facility has the capability of privately contracting with individual entities for the provision of services in the facility. As a result, oftentimes, non-State employees work on-site in a detention facility. These non-State employees frequently interact with detainees.

During the course of our investigation, we discovered that the Inspector Specialists employed by the Department of Juvenile Justice utilize Florida Department of Law Enforcement (hereinafter "FDLE") equipment to conduct preliminary criminal background screenings on potential employees. Both national and statewide background screenings are conducted for those employees working *directly* for a Department of Juvenile Justice facility. However, the Federal Bureau of Investigation prohibits Inspector Specialists from utilizing FDLE equipment to conduct preliminary national background screenings for those employees working for a *private entity* contracting with the Department of Juvenile Justice for the provision of services. 28 U.S.C. Sec. 20.33(a) is cited in support of this prohibition.[130] Final fingerprint screenings, including national background screenings, are completed on all private contractors and direct employees within approximately one to two months of the employee commencing employment. Thus, a worker employed at the facility through a private contract to provide drug counseling or medical care to detainees could potentially have significant, violent national criminal records and have direct contact with the detainees housed in the facility without the knowledge of the Department for a two to three month period.

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[129] We were not unmindful of the potential benefit of detainee exposure to ex-addicts and ex-felons. See, generally, A Comprehensive Therapeutic Community Approach for Chronic Substance-Abusing Juvenile Offenders: The Amity Model, Rod Mullen, Naya Arbiter, and Peggy Glider.

[130] This statute sets forth the perimeters governing the utilization of federal equipment for background screenings.

We are mindful of the limited resources endemic in our community. However, we learned in the course of our investigation that the Department of Children and Family Services recently purchased several "live scan" machines to conduct full, immediate background screenings on all potential employees. With a "live scan" machine, prospective employees insert their finger into the machine so that a fingerprint scan is obtained. This scan is then automatically and immediately checked against the criminal database files of local, state and federal law enforcement agencies.

We recommend that the Department of Juvenile Justice immediately begin the practice of conducting full national criminal background screenings on all workers, even non-direct care workers, employed in any facility housing our youth. As we are cognizant of limited resources, we recommend that the Department of Juvenile Justice require all potential privately contracted employees to report to the "live scan" machines recently purchased by the Department of Children and Family Services to quickly, efficiently, and economically conform with this recommendation.

B. ISSUES REGARDING DEPARTMENT OF JUVENILE JUSTICE EMPLOYEES WITH CRIMINAL BACKGROUNDS AND PENDING CRIMINAL CASES

In the course of our investigation, we were disturbed to learn of the many Department of Juvenile Justice employees with sordid criminal histories. We felt strongly that the individuals charged with caring for and rehabilitating our children should not have a history of engaging in destructive criminal activity or serious, pending criminal cases.

We learned that a new criterion by which employees were hired was developed following the creation of the Department of Juvenile Justice in 1994.[131] This criterion precluded employment for any employee who had been convicted of an enumerated, disqualifying offense.[132] However, employees hired by the Division of Health and Rehabilitative Services prior to the formation of the Department of Juvenile Justice who

[131] We noted, however, that individuals seeking employment with the Department of Juvenile Justice subsequent to October 1, 1999 with felony convictions or misdemeanor convictions involving perjury or false statement are *ineligible* for employment. See 985.406(3)(a) Florida Statutes (1999).

[132] A complete list of these offenses is set forth in the Department of Juvenile Justice Statewide Procedure on Background Screening. These offenses shall hereinafter be referred to as "enumerated, disqualifying offenses" for purposes of this report.

had been convicted of an enumerated, disqualifying offense were permitted to apply for an exemption or were simply permitted to continue working. Those who received exemption approvals were permitted to continue working for the Department of Juvenile Justice.

We learned that currently, nine employees who do not meet current Department of Juvenile Justice hiring standards work at the MDRJDC.[133] Their adult, criminal convictions vary from possession, manufacture, or distribution of marijuana to aggravated stalking, cocaine possession, robbery, and aggravated assault.[134] Further, we learned that between January of 1999 and November of 2003, fourteen MDRJDC workers were arrested.[135] Of those, four were convicted of crimes. Nearly all of these convictions involved substance abuse.

The Department of Juvenile Justice Office of the Inspector General requires each employee who is arrested during the course of his or her employment to report said arrest to the Office of the Inspector General Hotline. A misdemeanor arrest must be reported within twenty-four hours and a felony arrest must be reported within two hours. The Department of Juvenile Justice then tracks the outcome of the arrest. If conviction results and the offense is a disqualifying, enumerated offense, termination is the end result.

However, the Office of the Inspector General does not have the power to conduct an independent investigation on the merits of the arrest during the time the case is pending or if the arrest does not result in conviction. Thus, a technical defect in the arrest or charge that might result in a dismissal of the charge(s) would not warrant suspension or termination. Further, an arrest without an accompanying conviction for an enumerated, disqualifying offense would not warrant suspension or termination. A worker charged in a homicide case, which can oftentimes take years to proceed to trial, could conceivably maintain employment during the pendency of the case.

Although we were cognizant that an arrest alone should not result immediately in termination or suspension, we did agree that the Office of the Inspector General should be empowered to conduct an independent investigation regarding the merit of the charges

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[133] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated October 29, 2003.
[134] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated November 10, 2003.

upon arrest to prevent the continued employment of potentially dangerous or corrupt employees.

We were also deeply concerned when we learned that Department of Juvenile Justice employees are subject to a criminal background investigation "re-screening" only once every *five years*. Thus, if an employee fails to report his or her arrest or conviction, it is conceivable that the employee may continue working with youth until the arrest or conviction is discovered a number of years later.

We recommend that the Department of Juvenile Justice re-assess the current exemption policy and re-assess all employees who do not conform to current hiring standards. We recommend that all employees in direct-care positions be held to the same hiring standard, regardless of the date of their hire. We further recommend that the Department of Juvenile Justice empower its Office of the Inspector General to conduct independent investigations in tandem with law enforcement agencies into the circumstances surrounding the arrests of all direct-care workers charged with enumerated, disqualifying offenses to determine whether or not continued employment is prudent based upon the factual circumstances of that arrest. We recommend that employees convicted of an enumerated, disqualifying offense during their tenure at the Department of Juvenile Justice be terminated from employment and not be permitted to apply for an exemption. Finally, we recommend that each Department of Juvenile Justice employee be subject to criminal background investigation re-screening every year. In the event that it is revealed that an employee failed to report an arrest, we recommend that the Department of Juvenile Justice immediately terminate that employee.

C. NON-COMPLIANCE WITH QUALITY ASSURANCE STANDARDS IN THE FACILITY

The Florida Department of Juvenile Justice Quality Assurance system was established by the Florida Legislature in 1994 as part of the Juvenile Justice Reform

[135] Department of Juvenile Justice, Response to Subpoena Duces Tecum dated November 17, 2003.

Act.[136] Chapter 985, Florida Statutes, requires the Department of Juvenile Justice to submit an annual report to the legislature assessing the quality of its programs and services.[137] As such, the Bureau of Quality Assurance designates minimum program standards and makes a periodic inspection to determine whether or not each program throughout the state has complied with these standards. If a program fails to meet the established minimum standards, the Department of Juvenile Justice must take necessary and sufficient steps to ensure compliance with the minimum standards.[138] If the program fails to achieve compliance within six months, and the program has not documented extenuating circumstances, the Department of Juvenile Justice must notify the Executive Office of the Governor and the Legislature of proposed corrective action.

From 2001 to 2002, the MDRJDC suffered a decrease in its overall program performance and compliance ratings as determined by the Bureau of Quality Assurance.[139] In 2001, the Bureau of Quality Assurance determined that the facility had an "acceptable" performance range and was substantially compliant with statewide requirements.[140] By 2002, the facility was no longer achieving an acceptable performance, but was designated to be at a level of "minimal" performance.[141] Further, the facility was non-compliant with statewide standards.[142]

We noted that while the MDRJDC appeared to be struggling to conform to statewide standards, this was not the trend among other detention facilities in the State. The Bureau of Quality Assurance has instituted a "deemed status" program in which Department of Juvenile Justice programs achieving a performance rating of at least eighty percent and a compliance rating of at least ninety percent are granted special

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[136] Department of Juvenile Justice Office of the Chief of Staff, An Introduction to Florida's Juvenile Justice Quality Assurance System: *Promoting Continuous Improvement and Accountability in Juvenile Justice Programs and Services* revised March 24, 2003, at 2 and 7.
[137] Id.
[138] Id.
[139] At the time of writing this report, the Bureau of Quality Assurance Program Review for the MDRJDC, October 20-24, 2003 had just been published.
[140] Department of Juvenile Justice, Bureau of Quality Assurance Program Review for the MDRJDC, July 23-27, 2001.
[141] Department of Juvenile Justice, Bureau of Quality Assurance Program Review for the MDRJDC, July 8-12, 2002.
[142] However, in the most recent Bureau of Quality Assurance report, the MDRJDC was determined to be "acceptable."

consideration and not subjected to a full review at regular intervals.[143] The number of deemed or special deemed programs statewide has increased from forty-seven in 1997 to one hundred twenty-three in 2002.[144]

By 2002, the MDRJDC ranked *last* in the State based on performance standards for detention programs assessed by the Bureau of Quality Assurance that year.[145] It received a Quality Assurance performance score of just sixty-eight percent.[146] The facility failed to meet state standards for mental health and substance abuse.[147] The facility also failed to meet required minimum standards for behavior management.[148] Program performance regarding health services, program security, and living environment was determined to be *minimal*.[149] The Quality Assurance reviewers did, in assessing health services, take into consideration external control factors in assessing performance. Specifically, despite allowances made for the fact that MCH had recently assumed responsibility as the healthcare provider for the facility and was attempting to catch-up on old sick call requests and comprehensive physical examinations, health care services were still rated as minimal.[150] Overall, program performance was determined to be minimal and compliance was determined to be "non-compliance."[151] It should be noted that both the facility targeted for inspection and any subcontractors are placed on notice many months prior to a scheduled inspection.[152]

In the recently released 2003 report, the facility obtained an "acceptable" rating; however, it failed to meet statewide standards governing health services, mental health and substance abuse assessments, and school district management.[153] Program security,

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[143] Id. at III-1.
[144] Id.
[145] See Florida Department of Juvenile Justice 2002 Quality Assurance Report at VIII-7.
[146] Id.
[147] Bureau of Quality Assurance Performance Rating Profile MDRJDC (2002).
[148] Id.
[149] Id.
[150] Id.
[151] Id.
[152] Electronic mail correspondence between MCH and Department of Juvenile Justice employees dated March 24, 2003 reveals an effort to change the date of the Quality Assurance Inspection. The inspection was slated for July, 2003.
[153] Bureau of Quality Assurance Program Review for the MDRJDC, October 20-24, 2003.

transition, and service delivery were all characterized as meeting "minimal performance."[154]

The existing Quality Assurance system allows for a facility to be designated non-compliant, but as long as the facility obtains minimal performance (a rating of sixty to sixty-nine percent), it avoids a six-month review. In our minds, this allowed a facility to fall abysmally below standards in certain areas with no immediate recourse. This clearly presents safety concerns when designated areas of non-compliance and low performance include such urgent issues as health care.

We recommend that any facility determined to be non-compliant as defined by the Bureau of Quality Assurance be required to submit a written plan of action to remedy shortcomings within one month of the issuance of the relevant Bureau of Quality Assurance Report. We further recommend that any facility determined to be non-compliant be subjected to the same six-month follow-up review as a facility that fails to meet program performance standards. Finally, we recommend that the Department of Juvenile Justice implement immediate consequences for the superintendent of the facility rated as non-compliant.

D. ISSUES REGARDING LACK OF COMMUNICATION BETWEEN ADMINISTRATION AND STAFF IN THE FACILITY

We were confronted with numerous issues regarding supervision in the facility in the course of our investigation. We attributed many of these issues to the lack of effective communication mechanisms in the facility and the structure of the facility itself. However, some of these issues were symptoms of an overall lack of hands-on supervision.

We discovered that staff-supervisor communication issues have historically been a problem and often inure to the detriment of the youth housed in the MDRJDC. We learned in the course of our investigation about the failure of workers to provide detainees with requisite clean underwear and linens due to the failure of administration to dispense these items to the workers for appropriate distribution. We learned of staff members purchasing toothpaste for detainees with their own money, again due to the

[154] Id.

failure of administration to distribute necessities. What we found most outrageous about this was the apparent surplus of such items that accumulated due to the fear of administration that the workers would steal them.

Most striking, perhaps, in the contrast between the MDRJDC and the BRJDC, was the overall attitude of the staff.[155] We noted immediately in Broward that the Superintendent of the facility chose to make rounds several times a day. This, naturally, resulted in employees behaving in a much more efficient and professional manner. We further noted that the structure of the Broward facility was conducive to these rounds, as the shape of the facility did not permit any warning as to when these rounds would occur.

In the MDJRDC, staff was casual and measurably less professional. We learned that the Superintendent and Assistant Superintendents at the MDJRDC do not conduct surprise rounds. Further, the ratio of employees to administrators does not allow for frequent rounds.

The means of communication between staff and administration was also severely curtailed in the Miami-Dade facility. This could be partially attributed to the failure of the administrators to carry radios, as without radios, administrators are not privy to communication regarding serious issues in the facility.

This communication failure was particularly apparent on the evening of Omar's death. As previously noted in this report, one juvenile detention officer made numerous efforts to raise either medical personnel or a supervisor on the radio, but to no avail.

We recommend that the supervisors and superintendents in the facility be assigned the same radios as the staff members, in order to prevent communication failures. We further recommend that the Superintendent and Assistant Superintendents be required to complete several rounds per shift. We further recommend that the Superintendent and Assistant Superintendent be personally responsible for ensuring that detainees are provided with all necessities required by existing Bureau of Quality Assurance Standards.

[155] It should be noted that Broward has been designated a "deemed facility" for the past two years.

E. ***STAFF FAILURE TO COMPLY WITH OSHA REQUIREMENTS AND FACILITY OPERATING PROCEDURES REGARDING DISPOSAL OF BIOHAZARDOUS WASTE IN THE FACILITY***

Occupational Safety and Health Administration ("OSHA") provisions are incorporated into mandatory Bureau of Quality Assurance Standards to require mandatory "bloodborne pathogen" training for each detention worker in secure detention facilities throughout the State of Florida.[156] The purpose of this training is to ensure that workers take adequate precautions in handling biohazardous materials. Further, the superintendent of each secure detention facility is required to ensure that workers observe "universal precautions" in handling any materials containing blood or other bodily fluids.[157]

We discovered in the course of our investigation that detention workers were unaware of whether or not biohazardous waste kits even existed in the MDRJDC.[158] We further learned that it was permissible practice in the facility for staff members to assign detainees to a "detail" or "trustee" status. On the days preceding the death of Omar Paisley, these "detail" detainees were ordered to clean Omar's cell. This cleaning duty entailed the collection of sheets, pillowcases, and blanket and the mopping of the cell.[159] The detainees then placed the sheets, pillowcases, and blankets in a barrel to be forwarded to the laundry service.[160] These "detail" detainees were not provided with gloves, face masks, or any type of protective equipment to ensure against exposure to bodily fluids.

Facility Operating Procedures require that linens soiled with emesis be marked to ensure that laundry staff would "follow all biohazard procedures in sanitizing linen."[161] Interviews conducted with both detainees and laundry personnel reveal that Omar's linens were indeed soiled, but were not properly separated as required.

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[156] Bureau of Quality Assurance Standard No. 7.22.
[157] Bureau of Quality Assurance Standard No. 7.14(b); 7.14(c).
[158] See Sworn Statement of JDO Michael Johnson at 14.
[159] See Sworn Statement of A.H. at 17, 19; Sworn Statement of S.S. at 39.
[160] Id.
[161] As required pursuant to Department of Juvenile Justice MDRJDC Facility Operating Procedure 7.14 revised January, 2003 at 3.

***We recommend the facility take immediate action to train all employees regarding dangers associated with bloodborne pathogens and all other biohazardous waste. We further recommend that there be specific Facility Operating Procedures instituted to require that appropriate disciplinary action be given to any employee who either fails to comply with existing Facility Operating Procedures governing the disposal of hazardous waste or orders detainees to participate in the clean-up of biohazardous materials*.**

F. STAFF FAILURE TO COMPLY WITH FACILITY OPERATING PROCEDURES GOVERNING INFECTIOUS DISEASE

The MDRJDC is governed by a series of Facility Operating Procedures. These procedures define acceptable standards within the facility and address everything from appropriate employee dress to emergency evacuation plans. We noted a lack of compliance with the Facility Operating Procedures in the course of our investigation. While some lack of compliance had minimal impact, other failures contributed, in our opinion, to the death of Omar Paisley and heavily impacted the safety, security, and efficiency of the institution.

Facility Operating Procedure 7.14 sets forth a facility-wide criterion for infectious disease. Specifically, the facility definition of a communicable disease includes "the common cold [and] flu."[162] The relevant procedure mandates that "[a]ll detainees suspected of communicable diseases will be referred to the responsible physician for examination and treatment. The medical department will be notified to do an immediate assessment to determine if detainee (sic) needs to be isolated and if isolation precautions are indicated."[163] The procedures further specify "Cardiopulmonary Resuscitation and First Aid must be given to people who are in need of this life-saving procedure."[164]

Our investigation revealed, despite contentions by various detention workers and nurses that they believed Omar to be the victim of a virus, no effort was made to refer Omar to the physician. It is undisputed that the physician was at the facility on Monday, June 9, 2003, thus such a referral would have required minimal effort.

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[162] Department of Juvenile Justice MDRJDC Facility Operating Procedure 7.14 revised January, 2003 at 2.
[163] Id. at 3.

Further, despite the numerous individuals employed at the facility, not one attempted to perform lifesaving efforts on Omar Paisley. It is uncontraverted that detention workers were alerted to the fact that Omar did not have a pulse and was not breathing.[165] Yet, nobody attempted to perform cardiopulmonary resuscitation on Omar.

We recommend that the Facility Operating Procedures be amended to include immediate sanctions for the failure of a staff member to perform potentially lifesaving cardiopulmonary resuscitation or to administer first aid.

X. CONCLUSION

The tragic death of Omar Paisley has left us with clear insight as to the glaring deficiencies endemic in the Department of Juvenile Justice and its MDRJDC. During the course of our investigation, we have been keenly aware of public legislative hearings, other grand jury investigations, and probing media coverage all focusing on systemic flaws in the Department of Juvenile Justice. We are cognizant that it will take a great deal of time for our community to heal following the senseless death of Omar Paisley. We are acutely aware of just how important our role is in determining what change should be implemented to improve the dire, substandard conditions in the MDRJDC.

Our investigation has revealed a juvenile justice system plagued by a lack of commitment, a lack of supervision, a lack of guidelines, a lack of proper structure, and a lack of resources. As a result, we were forced to narrow our findings to the most egregious of issues. We have observed firsthand the most tragic result that inevitably ensues with the unchecked nonfeasance in a state-run facility.

We, as grand jurors, as parents, and as citizens of this community, cannot bear the thought of another child suffering unbearably and, ultimately, slipping through the cracks of our system. We are charged with ensuring the safety and protection of our youth. We are confident that the commitment of resources to our children will prevent future similar tragedy. Thus, we implore the Department of Juvenile Justice to begin to take greater responsibility for the children entrusted in its care, custody, and control. We recommend

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[164] Id.
[165] See Sworn Statement of Reverend Eddie Williams.

that our Legislature commit adequate resources to improving the quality of life for children housed in the MDRJDC. We strongly urge that our findings be widely recognized and our critical recommendations be implemented in an expeditious manner.

XI. SUMMARY OF RECOMMENDATIONS

1. *We recommend that the MDRJDC immediately install an intercom system comparable to the system currently in place in the BRJDC. As an immediate alternative during the installation process of the intercom system, we recommend that the current Facility Operating Procedures be modified immediately to provide for any employee noting an emergency situation to have unimpeded direct access to 911. This would require Facility Operating Procedures to reflect that any employee who perceives an emergency situation, must, as a matter of responsibility, call 911. This responsibility should, in our opinion, exist separate and apart from the mandates assigned to any medical personnel. Further, as a practical measure, we believe that a telephone system must be implemented in the facility in which each area populated by detainees is equipped with direct access to 911. Finally, we recommend that current Facility Operating Procedures be re-written to require detention workers to first contact 911 in an emergency situation, and only then to contact Central Control.*

2. *We recommend that the MDRJDC immediately implement a contingency plan for overcrowding/group arrest. We further recommend that such a plan include a designated overflow facility. The implementation of such a plan will prevent detainees from having to share quarters, will ensure that detainees are provided with adequate services, and will allay safety and security concerns.*

3. *We recommend the implementation of mandatory detainee-staff ratios. We recommend that each module be staffed by no less than two staff members at all times, with an overall staff ratio of eight to one during waking hours and sixteen to one during sleeping hours. We recommend that the Superintendent of the Facility bear personal responsibility for signing off on schedules to ensure that employees comply with this ratio.*

4. *We recommend that the facility implement a policy requiring a minimum of two workers at all times be assigned to Central Control. One worker should be specifically assigned to monitor the facility via the surveillance system and one worker should be specifically assigned to address all other duties in Central Control.*

5. *We recommend that the existing surveillance system be replaced immediately with a system that will allow for recording in each area of the facility. We further recommend that an inspection be implemented at the beginning of each shift to ensure that the surveillance system is working. We recommend that the Superintendent and Assistant Superintendents of the facility bear personal responsibility for confirming at the beginning of each shift that the surveillance system is working.*

6. *We recommend that health care requests be addressed on the same day they are issued. We further recommend that all detainees complaining of illness undergo complete physical examinations by medical personnel. These physicals should always include vital signs and blood work when necessary.*

7. *We recommend the immediate implementation of Facility Operating Procedures to address appropriate procedures governing medical request forms. These Procedures should include a requirement that detention staff members first provide ill detainees with medical request forms, collect said forms, and forward said forms immediately to medical personnel.*

8. *We agree with the Commission on Corrections and recommend that the Department of Juvenile Justice consult with the Department of Corrections and make every effort to build an in-house health services staff designed to provide comprehensive medical, dental, and mental health services for male and female detainees throughout the facility. This should include health education, preventative care, and chronic illness treatment plans at the minimum community standard of care.*[166] *We further recommend that the Department of Juvenile Justice designate a single Chief Medical Officer to oversee the medical care in each detention facility.*

9. *Until the in-house provision of medical care is finalized, we recommend the immediate implementation of a system whereby medical staff are required to report to Department of Juvenile Justice MDRJDC administration upon their arrival at the facility and prior to departing from the facility. We further recommend that Department of Juvenile Justice MDRJDC administration be responsible for certifying the hours worked by medical staff. Finally, we recommend the implementation of immediate, personal sanctions by a contracting medical entity for the failure by medical staff to coordinate emergency efforts.*

10. *We recommend that a physician be required to review in a timely manner the chart of each and every detainee rendered treatment by nursing staff. We recommend that this review include an analysis of follow-up treatment rendered and compliance with standing orders..*

11. *We recommend that health care workers who fail to document medical records, progress notes, the administration of medication, and follow-up treatment in an accurate and timely manner be subject to immediate, harsh sanctions.*

12. *We believe that the Broward system has obvious merit. We therefore recommend that this system be implemented in Miami-Dade County. After filling out a Youth Request for Sick Call, each youth should be accompanied to the Medical Center by a Detention Officer. The youth should then wait in the center until a health care worker is available. In the event that a detainee is too ill to walk, serious consideration should be given for immediate emergency transport at that time.*

13. *Based upon the size of the MDRJDC, we recommend the immediate implementation of twenty-four hour on-site medical care for all detainees.*

[166] See http://www.dc.state.fl.us/employ/health/index.html.

14. *We recommend that the Department of Juvenile Justice Office of the Inspector General report directly to the Chief Inspector General of the State of Florida in order to ensure the neutrality and the integrity of all investigations. We further recommend that the Department of Juvenile Justice receive input from the assigned Inspector Specialist in making disciplinary determinations as the result of any given investigation.*

15. *We recommend that the Department of Juvenile Justice immediately begin the practice of conducting full national criminal background screenings on all workers, even non-direct care workers, employed in any facility housing our youth. As we are cognizant of limited resources, we recommend that the Department of Juvenile Justice require all potential privately contracted employees to report to the "live scan" machines recently purchased by the Department of Children and Family Services to quickly, efficiently, and economically conform with this recommendation.*

16. *We recommend that the Department of Juvenile Justice re-assess the current exemption policy and re-assess all employees who do not conform to current hiring standards. We recommend that all employees in direct-care positions be held to the same hiring standard, regardless of the date of their hire. We further recommend that the Department of Juvenile Justice empower its Office of the Inspector General to conduct independent investigations in tandem with law enforcement agencies into the circumstances surrounding the arrests of all direct-care workers charged with enumerated, disqualifying offenses to determine whether or not continued employment is prudent based upon the factual circumstances of that arrest. We recommend that employees convicted of an enumerated, disqualifying offense during their tenure at the Department of Juvenile Justice be terminated from employment and not be permitted to apply for an exemption. Finally, we recommend that each Department of Juvenile Justice employee be subject to criminal background investigation re-screening every year. In the event that it is revealed that an employee failed to report an arrest, we recommend that the Department of Juvenile Justice immediately terminate that employee.*

17. *We recommend that any facility determined to be non-compliant as defined by the Bureau of Quality Assurance be required to submit a written plan of action to remedy shortcomings within one month of the issuance of the relevant Bureau of Quality Assurance Report. We further recommend that any facility determined to be non-compliant be subjected to the same six-month follow-up review as a facility that fails to meet program performance standards. Finally, we recommend that the Department of Juvenile Justice implement immediate consequences for the superintendent of the facility rated as non-compliant.*

18. *We recommend that the supervisors and superintendents in the facility be assigned the same radios as the staff members, in order to prevent communication failures. We further recommend that the Superintendent and Assistant Superintendents be required to complete several rounds per shift. We further recommend that the Superintendent and Assistant Superintendent be personally responsible for ensuring that detainees are provided with all necessities required by existing Bureau of Quality Assurance Standards.*

19. *We recommend the facility take immediate action to train all employees regarding dangers associated with bloodborne pathogens and all other biohazardous waste. We further recommend that there be specific Facility Operating Procedures instituted to require that appropriate disciplinary action be given to any employee who either fails to comply with existing Facility Operating Procedures governing the disposal of hazardous waste or orders detainees to participate in the clean-up of biohazardous materials.*
20. *We recommend that the Facility Operating Procedures be amended to include immediate sanctions for the failure of a staff member to perform potentially lifesaving cardiopulmonary resuscitation or to administer first aid.*

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
RICHARD THOMAS GIORDANI	Murder First Degree Kidnapping	True Bill
KEVIN EVERS	Murder First Degree Murder First Degree Murder First Degree Murder First Degree / With a Deadly Weapon / Attempt Murder First Degree / With a Deadly Weapon / Attempt Deadly Missile / Shoot, Throw Firearm/Weapon/Possession by Convicted Felon	True Bill
JESUS CHIRINO	Murder First Degree Firearm/Use, Display While Committing a Felony	True Bill
ARTHUR R. COLPITT III	Murder First Degree	True Bill
RODGER LOVETTE	Murder First Degree Robbery/Strong Arm With/Aggravated Battery Abuse/Aggravated/Elderly/Disabled Adult/ Phy/Psy	True Bill
JEFFREY S. WORLEY	Murder First Degree	True Bill
LAWRENCE S. BRYANT	Murder First Degree Robbery/Armed/Attempt Kidnapping/With a Weapon Burglary/With Assault or Battery/Armed Battery/Aggravated/Great Bodily Harm/ Firearm	True Bill
ANTOINE LINDSEY and PATRICK LINDSEY	Murder First Degree	True Bill
NATHANIEL STEVENS	Murder First Degree	True Bill
ENSI PRUDENT	Murder First Degree Firearm/Possession by Convicted Felon	True Bill
DUANE ISAAC WALKER	Murder First Degree Child Abuse/Aggravated	True Bill
JOSE GREGORIO MARCANO	First Degree Murder	True Bill
BARON EARL MOORE	Murder First Degree	True Bill
CHARLES D. BYRD	Murder First Degree Child Abuse/Aggravated/Great Bodily Harm/Torture Sexual Battery/On a Minor by an Adult	True Bill
TERRIC JEFFERY	Murder First Degree Child Abuse/Aggravated/Great Bodily Harm/Torture Child Abuse/Aggravated/Great Bodily Harm/Torture Child Abuse/Aggravated/Great Bodily Harm/Torture	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
DAVID DWAYNE BROWN, also known as "DABO"	Murder First Degree Murder First Degree Murder First Degree/Attempt Firearm/Concealed Weapon/Possession by Violent Career Criminal Firearm/Use, Display While Committing a Felony	True Bill
DANNY PIERRE-LOUIS (A) and RICHARD RAMBARAN (B)	Accessory After the Fact (A) (Murder) Accessory After the Fact (A) (Burglary) Murder First Degree (B) Burglary/With Assault or Battery/Armed (B) Aggravated Stalking/Deadly Weapon/Prior Restraint (B) Murder First Degree/Attempt (B) Stalking/Aggravated (B)	True Bill
ANDREW OMAR FOSTER	Murder First Degree Murder First Degree/Attempt Robbery/Armed/Attempt Burglary/Armed Firearm/Use, Display While Committing a Felony Firearm/Possession by Convicted Felon	True Bill
VICTOR EVELIO PESTANO and (A) DULIE ALONZO GREEN, JR. (B)	Murder First Degree Sexual Battery/Firearm/Deadly Weapon or Serious Injury Kidnapping/With a Weapon Robbery/Carjacking/Armed	True Bill
HECTOR DARIO TRELLEZ	Murder First Degree	True Bill
GAILE TUCKER LOPERFIDO (A) and DIANNE MARIE DEMERITTE (B)	Manslaughter/Aggravated/Child Under 18 (A) Manslaughter/Aggravated/Child Under 18 (B) Murder Third Degree (A) Murder Third Degree (B)	True Bill

ACKNOWLEDGMENTS

Nine months ago our only commonality was that individually we were part of a large grand jury pool. By the luck of the draw, our names were selected out of a fishbowl and at that moment we became the Miami-Dade County Grand Jury, Spring Term 2003.

Randomly selected, we were initially separated by age, ethnicity and cultural diversity. In spite of our differences, we quickly came together and formed a motivated team that possessed a strong desire to speak in a single voice.

This process and our accomplishments as jurors could not have been possible without the efforts of Chief Assistant State Attorney Don L. Horn who guided and educated us. Thank you for your direction and patience during these past months. For the portion of our term dealing with the Department of Juvenile Justice, we are indebted to Assistant State Attorney Bronwyn Miller for her unrelenting fervor in uncovering and exposing the problems with the Department of Juvenile Justice. She consistently led, enlightened and encouraged us.

To those witnesses who appeared before us and gave us a first rate education regarding the Department of Juvenile Justice, we offer our heartfelt thanks. We are truly grateful for the dedicated men and women of the various law enforcement agencies who provided us with critical testimony. Through their often-thankless efforts, professionalism and dedication we were able to make informed decisions.

The Grand Jury expresses its sincere gratitude to Rose Anne Dare, Administrative Assistant, and Nelido Gil, Bailiff, for their dedication and commitment to making the Grand Jury run efficiently and smoothly. Their professionalism and skills made our days enjoyable and our task easier to perform.

We also wish to convey our thanks to the Honorable Judge Judith L. Kreeger and State Attorney Katherine Fernandez Rundle for their continued commitment and many years of service to the Miami-Dade County community and the judicial system, which is an integral part of this great country in which we live.

Our task was difficult and our journey through the judicial system was at times disturbing, frustrating, surprising and enlightening. Ultimately, despite the great personal and professional sacrifices made by each of us, it was an experience we will never forget.

Respectfully submitted,

Connie Portela, Foreperson
Miami-Dade County Grand Jury
Spring Term 2003

ATTEST:

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Shirley Boyer
Clerk

Date: January 27, 2004