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

FALL TERM A.D. 2011

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INDEX

UPDATE AND FOLLOW-UP INTO THE SAFETY AND MEDICAL CARE PROVIDED JUVENILES IN CUSTODY IN FLORIDA'S DEPARTMENT OF JUVENILE JUSTICE

I. INTRODUCTION

On June 9, 2003, seventeen-year old Omar Paisley died in the custody of the Department of Juvenile Justice at the Miami-Dade Regional Detention Center. Following his death, a Miami-Dade County Grand Jury investigation ensued and a report was issued with many recommendations to the Department of Juvenile Justice for improvements to the juvenile detention system. On July 10, 2011, eighteen-year old Eric Perez died in the custody of the Department of Juvenile Justice at the Palm Beach Regional Detention Center. In connection with the death of Mr. Perez, the front page headline of the December 28, 2011 edition of The Miami Herald read, "6 fired in teen's death at lockup"[1]

> Six employees from a Palm Beach County Juvenile lockup were fired after an investigation into the death of a detained teenager. His agonizing final hours had been captured on tape.[2]

While reading the article, many of us were reminded of the death of a detained teenager here in Miami years ago, Omar Paisley.

During our term, the Palm Beach County Grand Jury released a report regarding its investigation into the death of Mr. Perez. Our grand jury decided that we would look into the facts surrounding the two deaths, examine the two grand jury reports and try to determine whether the second death might have been prevented if recommendations from the earlier report had been fully implemented. We found that there are many factual similarities and unfortunately, many of the same type failures that probably contributed to both deaths. However, we are pleased to report that the Department of Juvenile Justice (DJJ) implemented many of the prior recommendations, and in some instances, went above and beyond the import of the recommendations in an effort to prevent a repeat of the Paisley tragedy. Nevertheless, Mr. Perez was made to endure the pain he suffered because employees, supervisors and administrators failed to act in accordance with the post-Paisley policies and procedures implemented by DJJ. In other words, the second death might have been prevented had DJJ staff acted in accordance with or followed just a few of the recommendations set forth in the Miami-

[1] The Miami Herald, December 28, 2011
[2] Id.

Dade report. To make this point, we begin with brief summaries regarding each of the reports and each of the deaths. The summaries set forth below are derived primarily from the two prior grand jury reports. Following our report, we make recommendations for even further improvements.

II. THE PRIOR GRAND JURY REPORTS

In January 2004, the Spring Term A.D. 2003 Grand Jury issued its Final Report entitled, *Investigation into the Death of Omar Paisley, and the Department of Juvenile Justice, Miami-Dade Regional Juvenile Detention Center* (hereinafter, The Miami-Dade Report). The Miami-Dade Report centered on the "unnecessary" and "tragically preventable death"[3] of 17-year-old Omar Paisley, a detainee being held in the custody of the Miami-Dade Regional Juvenile Detention Center (MDRJDC). Despite his repeated complaints of pain and three (3) days of urgent requests for help, Omar died on June 9, 2003, due to the failure of those who were responsible for his care to provide appropriate medical intervention. In fact, 9-1-1 was not called until after he was already dead. As a result of that travesty, the Spring 2003 Term Grand Jury issued its report and was determined to make recommendations which, if implemented, would prevent another unnecessary (and maybe even preventable) death in the MDRJDC.[4]

More than seven (7) years later, on July 10, 2011, 18-year-old Eric Perez died in the Palm Beach Regional Juvenile Detention Center (PBRJDC). On March 8, 2012, the Winter Term 2012 Palm Beach County Grand Jury issued its Presentment of the Palm Beach County Grand Jury entitled, *Presentment Regarding the Death of Eric Perez While In The Custody of the Florida Department of Juvenile Justice* (hereinafter, "The Palm Beach Report"). The Palm Beach Report centered on the death of Mr. Perez and the Department of Juvenile Justice (DJJ) staff's failure to even "attempt to secure medical intervention for almost six and a half hours after Mr. Perez exhibited obvious signs of physical distress."[5] The Palm Beach Report, which "identifies the deficiencies, recommends changes in the DJJ training and policies, and proposes a new criminal statute prohibiting the neglect of youths in the custody of DJJ,"[6] had an overall

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[3] Final Report of the Miami-Dade County Grand Jury, Spring Term A.D. 2003, "Investigation Into the Death of Omar Paisley and The Department of Juvenile Justice Miami-Dade Regional Juvenile Detention Center, p. 1-2.
[4] Id.
[5] Presentment of the Palm Beach County Grand Jury, Presentment Regarding the Death of Eric Perez While In The Custody of the Florida Department of Juvenile Justice Winter Term 2012, p. 1.
[6] Id., p. 2.

goal which was "to ensure the DJJ is able to fulfill its mission while providing youths in the custody of the DJJ with adequate care and supervision."[7]

A. The Death of Omar Paisley

In June of 2003, Omar Paisley was in secure detention under the care of DJJ while being held in Module Three at the MDRJDC. Omar entered into a plea agreement and was waiting to be transferred and placed in a "moderate risk" residential program at Bay Point Schools. A psychiatric examination had to be conducted at MDRJDC before Omar could be placed at the Bay Point facility.

The day after Omar entered into the plea agreement, he began complaining of illness and pain in his stomach. These initial complaints started on Saturday morning, June 7, 2003. Omar filled out a "Youth Request for Sick Call" form, submitted it to a DJJ staff member and the Medical Station was notified of the medical complaint at 12:10 P.M. According to an entry in the logbook,[8] a Licensed Practical Nurse (LPN)[9] saw Omar at approximately 2:15 P.M.[10] Conflicts existed over whether the weekend LPN conducted a physical examination of Omar during that visit. She did, however, place Omar on a 24-hour liquid diet and ordered him on bed rest. Interestingly enough, this was exactly what should not have been ordered for someone complaining of "abdominal discomfort."[11]

Of note is the following entry from The Miami-Dade Report:

> 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 [a] LPN . . . After meeting with that detainee, [the] LPN . . . referred the detainee to the physician. The detainee was indeed

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[7] Id.

[8] A logbook is maintained in each module at the facility. Any action taken as to any detainee as well as all entries into the module, are to be recorded into the log contemporaneously with the action or the entrance.

[9] Having nurses at the facility was a provision of a contract between The Miami Children's Hospital and the Department of Juvenile Justice.

[10] Two LPNs professed to have made additional visits beyond those reflected in the logbook. In fact, one of the LPNs prepared an addendum to the logbook after Omar's death that indicates she made more visits and even conducted physical examinations of Omar. Those entries in the addendum were not corroborated by the other detainees or the Juvenile Detention Officers. We have intentionally restricted our recitation of visits and contacts between the LPNs and Omar to the contemporaneous entries that were in the logbook at the time of Omar's death.

[11] Spring Term A.D. 2003 Miami-Dade County Grand Jury Report, p. 6, footnote 23.

> physically examined by the physician and later transferred to the emergency room.[12]

A physician was not available at the MDRJDC the next day, because the physician is never scheduled to be at the facility on the weekends.

Omar's psychiatric evaluation was conducted by the psychiatrist at approximately 3:45 P.M. on Saturday afternoon. He was still in physical distress and the psychiatrist thought he was "sick with a stomach virus."

The next day, Sunday, Omar continued to complain of abdominal pain. However, now he was experiencing bouts of vomiting and diarrhea. The weekend LPN saw Omar at approximately 9:00 A.M. Again, conflicts existed over whether that LPN conducted a physical examination of Omar at that time. She did not return to check on Omar that day nor did she contact the physician that Sunday. No one called 9-1-1.

On Monday morning, Omar woke up very early (at 5:30 A.M.) requesting medical care. The Juvenile Detention officers noted he was in severe distress and mentioned same to the weekday LPN at breakfast. By this time, Omar was continuing to vomit and was now excreting on himself. Omar was in so much pain at this point that he was unable to even get out of the bed. Although there were four medical personnel working at the facility that Monday, Omar was only seen by an LPN. Various Juvenile Detention Officers voiced concerns throughout the day about Omar's worsening condition. Several calls over the radio summoning the weekday LPN to come check on Omar went unanswered. She did not respond to any of these urgent pleas from the DJJ staff. No one called 9-1-1.

At approximately 7:00 P.M. on Monday evening, Juvenile Detention Officers were finally able to make radio contact with the weekday LPN. Although she indicated on several occasions that she would respond to the module to check on Omar, she never did, often indicating she was "busy with other things." Astoundingly, that nurse told one Juvenile Detention Officer that she did not wish to examine Omar because "she had a sick child at home." Approximately an hour after DJJ staff made radio contact with the weekday LPN, she finally made contact with Omar. Instead of going into the cell, she ordered Omar, who could barely

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[12] Id., p. 7

move, to come out of the cell. Again, she stated that she had a child at home whom she didn't wish to contaminate with Omar's virus.[13] Still, no one called 9-1-1.

After seeing Omar, the weekday LPN called her supervisor, the Registered Nurse (RN), and thereafter completed the paperwork authorizing Omar's transfer to Jackson Memorial Hospital (JMH) for emergency treatment. She recorded on the paperwork that Omar's temperature was 98.5 and his pulse was normal. She told the Juvenile Detention Officer at Central Control that Omar was delusional. Surprisingly, she then left the facility. She did not call 9-1-1 although she was ordering Omar's transport to JMH for "emergency" treatment.

Omar continued sitting, slumped over in the chair outside his cell. Eventually, brown fluid flowed from his nose and mouth. Later that night, someone visiting the facility saw Omar in the condition he was in and attempted to take his pulse. Omar did not have a pulse. This occurred at approximately 9:00 P.M. Central Control, totally unaware of this development, called 9-1-1 at exactly 9:01 P.M. Omar was non-responsive when the paramedics arrived eleven (11) minutes later. At 9:43 P.M., Omar was declared DOA at JMH. The first calls to the doctor overseeing the detention facility were made between 10:30 and 11:00 P.M. – after Omar was already dead. By the time the first call was made to 9-1-1, Omar had suffered and languished in pain for at least fifty-seven (57) hours. Contrary to the assumptions of the weekday LPN, Omar never had a contagious "virus." Instead, an autopsy would reveal that Omar died from a ruptured appendix, a condition that was treatable had he received "timely" emergency medical treatment. None of the events described above were preserved for reviewing as the video equipment being used could not record the images captured on the surveillance cameras.

B. <u>The Death of Eric Perez</u>

In July 2011, Eric Perez was in secure detention under the custody of DJJ while being held at the Palm Beach Regional Juvenile Detention Center (PBRJDC). Mr. Perez turned eighteen (18) years old on July 2, 2011. Even though at 18, the State of Florida considered him an "adult," Mr. Perez was still detained at a juvenile detention facility because Florida law gives Juvenile Courts continuous jurisdiction over any person who commits an offense prior to his 18th

[13] We find it ironic that in her effort to protect "her child," she chose to intentionally not fulfill her duties and responsibilities as to "someone else's child." The fact that her negligence contributed to the death of "someone else's" child causes us to question whether she ever fully appreciated her role as one of the medical caretakers of these confined children.

birthday. That continuing jurisdiction remains until that person turns nineteen years old.[14] That is the posture Mr. Perez was in during the month of July 2011; no longer a child, but in the criminal justice system under these facts, not yet an adult.

On Saturday, July 9, 2011, at approximately 7:40 P.M., Mr. Perez left his module with other detainees to go to the cafeteria to eat snacks. It is forbidden for detainees to take uneaten snacks out of the cafeteria and back to their module or cell. Mr. Perez and his module mates were searched.[15] Video tapes revealed that the DJJ officers appeared to be laughing and joking with the detainees while the searches were being conducted. While conducting the search of Mr. Perez, the DJJ officers tossed Mr. Perez in the air. In the process of flying through the air, Mr. Perez struck the wall and/or the floor with his head and/or shoulder. Videotaped comparisons between Mr. Perez's agility before and after this trauma reveal a "marked change in his mobility." Immediately after landing on the floor, Mr. Perez was visibly unsteady on his feet. This unsteadiness was still visible upon his return to his module (housing unit). Shortly thereafter, his movements "appeared" to return to normal.

Around 9:30 P.M., Mr. Perez was sent to his cell to go to bed. At approximately 1:30 A.M., one of Mr. Perez's cellmates called a DJJ officer, reporting that Mr. Perez was screaming "get it off me, get it off me!" Later, Mr. Perez began screaming louder and repeating "it's going in my eye, it's going in my eye!"

The officer who responded to the cellmate's plea called the supervising officer. Both officers responded to Mr. Perez's cell where they observed him staggering around inside his cell. At some point, Mr. Perez lost the ability to stand. The officers asked Mr. Perez to exit his cell. He did so by crawling out. Once he crawled out into the main area of the module, Mr. Perez began rolling side-to-side in a rocking motion. As the officers tried to talk to him, Mr. Perez began screaming, "it hurts, it hurts," apparently referring to his head. At some point, Mr. Perez rose to his feet. Although he was successful in getting all the way up by using the wall for balance, he eventually stumbled forward and fell.

In the video, it appears that Mr. Perez struck his head on the corner of a table when he fell. The officers who watched this later placed a mattress pad on the floor of the main module

[14] Florida Statutes 985.03(6) and 985.0301

[15] These events were all recorded from the security video surveillance cameras located throughout the PBRJDC.

area and helped Mr. Perez down and onto the pad. They covered him with bed sheets and Mr. Perez appeared to fall asleep. No one called 9-1-1.

Less than an hour later (at approximately 2:22 A.M.), Mr. Perez vomited on the floor. He sat up, but did not get up from the mattress pad. Thereafter, he defecated in his underwear. Detention officers tried lifting Mr. Perez to his feet. He was not able to stand and fell back to a seated position on the mattress pad. No one called 9-1-1.

At 2:34 A.M., the supervising officer called the superintendent of the facility and reported that Mr. Perez was vomiting. There is no evidence to indicate the supervising officer provided the superintendent with information about (1) detention officers throwing Mr. Perez into the air and his apparent banging of his head/shoulders on the wall and floor; (2) Mr. Perez's physical instability following that event; (3) Mr. Perez's apparent hallucinations while in his cell; (4) Mr. Perez's screaming repeatedly that his head hurt; (5) Mr. Perez's inability to stand and his subsequent fall and apparent striking of his head on the table; (6) Mr. Perez's loss of his ability to control his bowels; and (7) Mr. Perez's then present inability to stand again. Based on the limited information provided, the superintendent instructed the supervising officer to call the nurse to see what advice she offered. The supervising officer was unable to locate the telephone number for the nurse. Mr. Perez became unresponsive before the supervising officer found the nurse's phone number. No one called 9-1-1.

Once the supervising officer found the number, he made two calls between 2:39 A.M. and 3:07 A.M. Neither of the calls was answered. The nurse being called was not on-call and therefore had no obligation to monitor or answer her phone during these off-hours on the weekend. After failing to reach the nurse, the supervising officer placed another call to the superintendent at 3:08 A.M. In this call, he reported his inability to reach the nurse and advised that Mr. Perez was now asleep. The supervising officer did not call 9-1-1.[16]

Officers attempted to clean up the vomit and excrement as Mr. Perez slept on the mattress pad. At approximately 5:15 A.M. on Sunday, one of the officers tried to get Mr. Perez cleaned up by taking him to the shower. That effort did not work because the officer discovered that Mr. Perez could not stand on his own. Instead, at approximately 5:33 A.M., several officers ended

[16] An excerpt from the Palm Beach County Report reads as follows: "The Grand Jury heard testimony from an officer on duty that she overheard the supervisor state that he did not call 911 because he thought the youth was faking and he did not want to fill out the extra paperwork." p. 8.

up dragging the mattress pad (with Mr. Perez on it) to one of the medical confinement cells. They placed pillows around the mattress, propped up his legs and again covered Mr. Perez with sheets. Mr. Perez fell asleep again and began snoring. Still, no one call 9-1-1.

A Juvenile Detention Officer (JDO) was stationed just outside of the door of the medical confinement cell. The supervising officer closed the door to that cell at 6:05 A.M. The JDO checked on Mr. Perez every ten (10) minutes by looking into the medical confinement cell. The detention officer continued with these periodic checks until approximately 7:51 A.M. It was around that time that one of the detention officers noticed that he did not hear Mr. Perez snoring anymore. The supervising officer re-opened the door to the medical confinement cell and discovered that Mr. Perez was cold to the touch. Upon discovering that Mr. Perez had a "very light pulse,"[17] the supervising officer called a "Code White" [18] over his radio seeking immediate medical attention.

The first call to 9-1-1 was made at 7:57 A.M. The paramedics who arrived seven (7) minutes later were unable to resuscitate Mr. Perez and pronounced him dead at 8:09 Sunday morning. By the time the first call was made to 9-1-1, Mr. Perez had exhibited numerous signs (or symptoms) of medical distress for a little more than twelve (12) hours. Contrary to the suspicions of the supervising officer, Mr. Perez was not "faking." Instead, an autopsy revealed that he died from a cerebral hemorrhage. The autopsy also revealed that there was no visible or discernible external trauma that would have produced a cerebral hemorrhage. Finally, of the several experts who reviewed the video footage and examined Mr. Perez's brain, none could give an expert opinion that the cerebral hemorrhage was connected in any way to the fall in the cafeteria or the subsequent fall in the living quarters. Accordingly, the Palm Beach County Grand Jury concluded there was no certainty that prompt medical attention would have saved the life of Mr. Perez.

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[17] Having a "light pulse" was inconsistent with the opinion of the Medical Examiner who viewed the videotape of Mr. Perez's final hours of life. Mr. Perez's last visible movement occurred around 7:00 A.M. The 7:00 A.M. movement consisted of Mr. Perez's arms moving slightly out from his body. After he was placed in the medical confinement cell the detention officers placed Mr. Perez's arms on either side of his body. The Medical Examiner opined that Mr. Perez died contemporaneously with the 7:00 A.M. movement. Mr. Perez could not have had a very light pulse at 7:51 A.M.

[18] A "Code White' is an urgent call summoning help for an emergency medical condition that exists within a juvenile detention facility. All designated health providers, DJJ Officers and staff know that when a Code White is issued over the radio, a situation exists that requires immediate medical attention. Designated DJJ Officers, supervisors and health professionals are required to respond immediately upon issuance of such a distress call.

C. The Similarities

Upon reviewing and comparing the narrative accounts in both grand jury reports, we note a number of similarities. Each detainee:

- Died in the custody of the state;
- Had no ability to seek or secure his own medical care;
- Had family members who had no ability to seek or secure medical treatment for the detainee;
- Exhibited signs of some medical distress while in DJJ custody;
- Exhibited physical conditions that worsened with the passage of time;
- Was observed by various Juvenile detention officers who were aware of the detainee's worsening condition;
- Vomited and defecated on himself;
- Suffered because a doctor was not called on his behalf;
- Was unable to walk out of his cell when requested to do so;
- Exhibited signs and symptoms that should have resulted in calls to 9-1-1 or for other emergency assistance;
- Was eventually attended to by Emergency Medical Technicians; and
- Had emergency medical services summoned on his behalf at, near or after the time of death.

In reviewing the two incidents and in light of the attendant grand jury reports, it appears that the Omar Paisley tragedy occurred, in part, due to certain policies and procedures at the MDRJDC that precluded JDO's who were trying to help Omar from calling 9-1-1. Following issuance of the recommendations in the Miami-Dade Grand Jury Report, the Department of Juvenile Justice made changes and instituted new policies and procedures to prevent a repeat of the Paisley incident. It appears that the Eric Perez tragedy was not a repeat of the Paisley incident and it occurred because staff, supervisors and administrators failed to follow the new policies and procedures that were in effect. We believe these two broad statements are supported by our investigation, specifically DJJ's responses to many of the recommendations from the Spring Term A.D. 2003 Grand Jury Report. Below, we discuss some of those recommendations, note some of the changes made by DJJ and make some renewed and new recommendations.

D. Florida Statute 827.03, Neglect of a Child

Even if members of the Palm Beach Grand Jury had irrefutable evidence that the JDO's failure to provide medical services directly caused the death of Eric Perez, they would not have

been able to file charges. The Miami-Dade County Grand Jury filed charges against two (2) LPN nurses in the Omar Paisley case. The charges were Aggravated Manslaughter of a Child and Third Degree Murder. Both charges stemmed from the nurses' failure to provide medical care and/or services necessary to maintain the **child's** physical health. This language flows from Florida's statute governing Abused Children:

> e) "Neglect of a child" means:
> 1. A caregiver's failure or omission to provide a child with the care, supervision, and services necessary to maintain the child's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the child; or
> 2. A caregiver's failure to make a reasonable effort to protect a child from abuse, neglect, or exploitation by another person.
>
> Except as otherwise provided in this section, neglect of a child may be based on repeated conduct or on a single incident or omission that results in, or could reasonably be expected to result in, serious physical or mental injury, or a substantial risk of death, to a child.[19]

The statute further provides:

> (b) A person who willfully or by culpable negligence neglects a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the second degree.[20]

The absolute bar to filing charges in the case involving Mr. Perez stems from the statute itself: it criminalizes the abuse or neglect of a "child." Although Mr. Perez was in a "juvenile" detention facility, he was not a juvenile, nor was he a "child" in the eyes of the law. The applicable language states:

> As used in this chapter:
> (2) "Child" means any person under the age of 18 years.[21]

Mr. Perez had just turned 18 years old a few days before his death. This simple fact would have made criminal prosecution under the statute impossible. We believe this is a glitch or an oversight in the law and therefore, *we join the West Palm Beach Grand Jury in recommending that the Florida Legislature amend Florida Statute 827.01 to define child as any*

[19] Florida Statute 827.03 (1)(e)
[20] Florida Statute 827.03 (2)(b)
[21] Florida Statute 827.01 (2)

person under the age of 18 years old or any person being held in the custody of the DJJ or in the custody of any of the DJJ's contracted program providers.

III. DJJ'S RESPONSIVENESS TO THE SPRING TERM A.D. 2003 GRAND JURY REPORT

In this section of the report, the Grand Jury will focus on some of the most critical recommendations that were included in the Spring Term A.D. 2003 Miami-Dade Report. The recommendation, or portion of the recommendation, is italicized below and followed by a brief explanation of what led to the recommendation and/or how DJJ responded thereto.

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.

Our predecessor grand jury toured the MDRJDC. While there, they attempted to dial 9-1-1 from one of the modules and discovered the telephone did not permit direct access to 9-1-1. Further, at that time, MDRJDC, Facility Operating Procedure 7.13 required that 9-1-1 be "... called by the shift supervisor as needed."[22] Workers were required to first contact a shift supervisor and 9-1-1 calls would be approved and routed through Central Control.

Today, all staff at the MDRJDC has unimpeded direct access to call 9-1-1 directly. There is no shift supervisor approval required nor must the request be made through Central Control. Further, there are telephones placed inside each of the modules at the MDRJDC that are now able to access 9-1-1.

This would require Facility Operating Procedures to reflect that any employee who perceives an emergency situation must, as a matter of responsibility, call 911.

At the time Omar Paisley was being detained, the culture at the MDRJDC was one of fear as it related to DJJ Officers reaching out to outside agencies. In fact, the Grand Jury Report notes specific instructions communicated by the Superintendent of the Facility to staff members prohibiting them from contacting external agencies without specific prior Superintendent approval.[23]

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[22] Spring Term A.D. 2003 Miami-Dade County Grand Jury Report, p. 13, footnote 66.
[23] Id., p. 13.

Today, any DJJ officer or staff member who witnesses or perceives an emergency situation or condition is now empowered and encouraged to call 9-1-1 directly. This change in policy and philosophy is corroborated by the Monthly Training Bulletin issued by the Superintendent of the MDRJDC.

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.

Facility Operating Procedures have been rewritten to do away with the requirement to contact Central Control before a call can be made to 9-1-1.

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.

The prior Miami-Dade Grand Jury Report noted that of the then 25 juvenile detention centers in Florida, the MDRJDC was, by far, the largest in the state. Further, although the funded operating capacity of the center was 226 beds,[24] on any given day the average daily population was 304 detainees.[25]

Today, under the direction of the present Secretary of DJJ, Wansley Waters, there has been a reduction in the total number of funded beds in Florida's juvenile detention centers. Moreover, the funding operating capacity at MDRJDC has been reduced from 226 beds to 121 beds, with an average daily population of 100 detainees. As a result of this reduction, several modules at MDRJDC have been closed and the overcrowding problem no longer exists.

We recommend that the existing surveillance system be replaced immediately with a system that will allow for recording in each area of the facility.

Although a surveillance system was in place at the MDRJDC during the three (3) days Omar Paisley complained of pain, the system was not able to record the images being captured by the various surveillance cameras located throughout the facility.

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[24] Id., p. 3
[25] Id., p. 15.

Today, the MDRJDC has a working surveillance system that allows for monitoring of the facility from various surveillance cameras located throughout the various modules. The present system also automatically records all images captured from the surveillance cameras. Absent any special circumstances or requests, the surveillance video recordings are retained for thirty (30) days.

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

This is one recommendation that to date has not been implemented. We address this issue below.

IV. PROVIDING MEDICAL CARE TO DETAINEES IN DETENTION FACILITIES

The Department of Juvenile Justice does not directly employ doctors, dentists or nurses to provide medical, dental and mental health services to the juveniles housed in its detention centers across the State of Florida. Instead, the detention centers issue Requests For Proposals (RFPs) seeking bids from health care providers which, for a fee, will provide certain services, a certain number of medical professionals and certain time schedules for which the medical professionals will either be at the facility or on-call. The RFP and the contractual agreement between the detention center and the health care provider also define how, when, where and what treatment will be provided. Most treatment is provided on-site. However, some emergency or critical medical conditions may require transport to an area hospital. The circumstances and manner in which such transfers are made might also be set forth in the contractual agreement between the detention center and the medical provider.

In addition to the contract, DJJ (through its Rules and Regulations) and each detention center (through its Facility Operating Procedures) also have requirements for staff regarding their obligations to assist DJJ in ensuring that all detainees receive timely medical attention. The Facility Operating Procedures (FOPs) and the DJJ Standards also dictate how requests for medical services are handled in the facility. Contrary to the preparation and physical delivery of a written form to the medical clinic that existed during the Paisley incident, requests for routine medical complaints are now typed into a computer system from the module housing the detainee and sent electronically to the medical clinic.

The Detention Facility Management System (DFMS) is now the mechanism through which sick calls are made. The DFMS was installed on detention center computers in June 2004, six (6) months after release of the 2003 A.D. Spring Term Grand Jury Report. Training of all staff at MDRJDC was conducted in March 2005 and all staff began making computerized sick call notices and documenting the sick call encounters in DFMS in June 2005. As of July 18, 2012 the data from MDRJDC reveals:

- 18,633 is the total number of sick call requests documented in DFMS;
- 7.14 is the average number of sick call requests per day; and
- .55 is the average number of days it takes to respond to a sick call request.

Using the DFMS provides a date and time stamp for the information sent and services requested. The time and type of medical services provided are also entered into the DFMS. Once an entry is made, the information can be amended (added to) but it cannot be altered. The computer system also allows for monitoring and quality assurance checks based on how long it takes for the medical professionals to access and respond to the initial request for medical services. In fact, DJJ has hired a Regional Nurse Consultant whose job responsibilities include monitoring, on a quarterly basis, the computerized data submitted from each facility and the center's effectiveness in the delivery of medical services to the detainees. The Regional Nurse Consultant is also empowered to make recommendations to DJJ for changes in policy or procedure should she discover systemic problems during her quarterly or annual checks. We commend DJJ for implementing both these ideas.

A. The Provision of Health Care For Juvenile Inmates at Adult Correctional Facilities

We understand from our months of service as grand jurors that there are some juveniles, like the ones we indicted for First Degree Murder, whose cases were transferred to the adult system for prosecution. Similarly, other juveniles who committed serious violent felony offenses and/or had lengthy criminal records have cases that were direct filed into the adult system. We were informed that there are approximately fifty-five (55) such persons in these combined categories. The group of fifty-five (55) includes thirty-two juveniles charged with the following offenses:

- 4 charged with murder
- 4 charged with attempted murder

- 3 charged with armed carjacking
- 3 charged with armed burglary
- 19 charged with armed robbery with a firearm

These juveniles are housed in a designated section at the Turner Guilford Knight (TGK) Correctional Center and kept separate and apart from the adults in that facility. These juveniles, as well as the adult inmates, are in custody under the supervision of Miami-Dade Corrections & Rehabilitation (MDC&R) and the Correctional Officers who work within such adult detention centers.

A written agreement exists between MDCR and the Public Health Trust designating Corrections Health Services (CHS) as the health authority responsible for providing medical, dental and mental health services for all inmates in adult detention facilities in Miami-Dade County. The health services provided by CHS must be in compliance with, among other standards, required federal, state, and local regulations, Florida Model Jail Standards and National Commission on Correctional Healthcare (NCCHC) Standards for Health Services in Jails. [26] At certain hours and days of the week, physicians are present at TGK's Medical Clinic. At any hour of any day, a physician is "on call" for the provision of medical services to adult and juvenile inmates at the TGK facility. Most importantly however, at TGK, CHS operates a medical clinic that is staffed with nurses 24 hours a day, seven days a week.

B. The Provision of Health Care For Detainees at MDRJDC

A written agreement exists between DJJ and First Care Home Services, Inc., designating Maxim Health Services, Inc. (Maxim) as the health authority responsible for providing designated medical services for all detainees at MDRJDC. There is a medical clinic at MDRJDC; however, unlike the one at TGK Correctional Center, it is **not** staffed with nurses twenty-four (24) hours a day, seven (7) days a week. Pursuant to the contract with Maxim, a Florida licensed physician serves as the Designated Health Authority (DHA) for MDRJDC. The DHA is responsible for the overall direction of the persons, policies, and procedures in the provision of medical health care services within the facility. In accordance with the terms of the

[26] Miami-Dade Corrections and Rehabilitation Department, Volume No. 14, DSOP 14-008, p.2

contract, the DHA provides on-site care for the facility five (5) hours per week and is on-call to MDRJDC twenty-four (24) hours a day, seven (7) days a week.

The DHA has delegated routine clinical responsibilities at MDRJDC to an Advanced Registered Nurse Practitioner (ARNP). In addition to providing the services of a traditional Registered Nurse, the ARNP is authorized to write prescriptions. The ARNP, contractually, provides on-site care at the MDRJDC facility sixteen (16) hours per week. One Registered Nurse (RN), three Licensed Practical Nurses (LPNs) and a Medical Records Clerk, round out the rest of the Maxim staff that works at MDRJDC.

Pursuant to the contract, the RN works forty (40) hours per week and the three LPNs combine for one hundred twenty (120) hours per week, on-site. None of the nurses are ever on-call. Further, the contract has a maximum number of annual work hours for each medical professional who provides medical services at MDRJDC and they are not to exceed the maximum number of hours allocated for each fiscal year. The contract also sets forth the rate of pay per hour for each position. Assuming all workers work the maximum number of hours each fiscal year, the compensation to be paid on the fixed rate contract shall not exceed $1,139,884.20.

With the limited number of personnel and in light of the limitation of work hours imposed by the clear terms of the contract, medical care for youth at MDRJDC is provided from 6:00 a.m. to 11:00 p.m. Monday through Friday. Again, the Designated Health Authority, the licensed physician, is on call twenty-four (24) hours a day, seven (7) days a week. Every night during the week and every weekend there is no medical professional at the facility unless the DHA is called and he determines he must come to the facility. Both Paisley's and Perez's death occurred over the weekend. Further, another youth who got sick at MDRJDC the day before Paisley began complaining of pain was seen by the doctor and transported to Jackson Memorial Hospital. He was fortunate in that he got sick on Friday, a day that the doctor was "in". Had Paisley's pain begun a day earlier he too, might not have died. The safety, health and treatment of the detainees cannot be based on the day or time of day they get sick, i.e., if you get sick during the week you have better treatment than if you get sick during the night or on the weekends.

As we stated earlier, violent juvenile offenders and those with the worst criminal records end up with their cases being sent to adult court. As a result, they are housed at the Turner Guilford Knight Correctional Center, an adult detention facility where CHS operates a medical clinic that is staffed with nurses twenty-four (24) hours a day, seven (7) days a week. Juveniles who commit less serious offenses and have no (or fewer) prior offenses remain in the custody of the Department of Juvenile Justice at the Miami-Dade Regional Detention Facility. Should those juvenile offenders who have committed the least serious crimes be put at a greater risk of dying in custody due to the juvenile detention facilities' inability to provide "round the clock" staffing of medical professionals? Alternatively, do we care more about providing medical treatment for hardened adult criminals and dangerous juvenile offenders than we do for our teenage children who might have had a slight brush with the law? We have to seriously consider whether that is the reality of our present situation. As we choose for that **not** to be our reality we **could** recommend that MDRJDC operate a medical clinic that is staffed with a nurse (or nurses) 24 hours a day, seven days a week. However, because that is impractical due to budgetary constraints, *we recommend that a Registered Nurse should be at MDRJDC, at a minimum, five (5) hours a day, seven days a week (this would be done to ensure the presence of an RN on-site every day and every weekend).*

V. JUVENILE DETENTION OFFICERS

Notwithstanding contractual agreements, rules, regulations or FOPs, the most important person responsible for the effective and efficient delivery of medical care in detention facilities is not the health professional; it is the Juvenile Detention Officer (JDO). The JDOs spend more time interacting with and observing the detainees under their charge. They should be the first to note any changes in the detainees' physical, mental or emotional well-being. Furthermore, as they are usually the ones sending (now e-mailing) the requests for medical services, they are also the ones who know directly how long it takes for the care requested to be provided. In both the Paisley and Perez situations, JDOs had much more information than the health professionals.

In the Paisley incident, the JDOs were aware of the detainee's deteriorating condition, made numerous requests for treatment on Paisley's behalf and became frustrated when their repeated S.O.S. calls went unanswered and Paisley failed to get the medical attention he desperately needed. In the Perez incident, the JDOs were aware of the detainee's deteriorating

condition, made feeble attempts to obtain treatment for Perez only after speaking to an off-site supervisor, and in spite of Perez's obvious physical distress, did not issue a "Code White" until Perez was already dead.[27] When the JDOs first realized that emergency treatment was needed and was not being provided, they all exercised bad judgment in failing to do the one simple thing that each of us would have done in that situation – pick up the phone and dial 9-1-1.

A. Training of Juvenile Detention Officers

As DJJ Officers play such a critical role in the delivery of medical services, their training is critically important. We are pleased to report that administrators at MDRJDC now conduct monthly training that, in part, focuses directly on this issue. Further, every month the MDRJDC's Office of Staff Development issues a Training Bulletin on the topic, Accessing 911. The Training Bulletin directly addresses many of the shortcomings that occurred in the Paisley incident. For instance, each Training Bulletin issued by the Superintendent in 2012 has included the following language:

> Officers should always review sick call requests to determine if the issue documented warrants immediate attention....Officers should also be conducting a visual assessment of the youth's current physical condition (e.g. sweating profusely, slurring his words, disoriented, etc.) to determine if the issue is a medical emergency.... If it is determined that the issue is a medical emergency, then the officer shall call a Code White and continue to follow facility operating procedures regarding emergency medical care.
>
> Any Officer, Contracted Employee, Teacher, or Volunteer has the right and responsibility to contact "9-1-1" (emergency services) if they feel that a situation exists that is of a potentially life-threatening nature involving a youth within this facility.
>
> Officers will call 9-1-1 using the nearest available telephone. If there is no telephone available, the officer is to use their radio to request assistance from Master Control, who will, without question or delay, call in the 9-1-1 requests for emergency transport. After contacting 911 emergency services, the officer will then notify Master Control and the Supervisor to advise of the 9-1-1 request. This will allow the facility to prepare for emergency services' arrival and ensure the first responders do not waste time in locating the source of the emergency.[28]

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[27] See Footnote 17

[28] Miami-Dade Regional Juvenile Detention Center Office of Staff Development Training Bulletin, July 1, 2012.

In addition to the information contained in the Training Bulletins, Facility Operating Procedures at MDRJDC provide that Officers should treat no head injuries, especially if it appears to be severe. The FOP further provides:

> *CAUTION SHOULD BE USED WHEN HEAD INJURIES OCCUR TO ASSURE THE YOUTH IS NOT IN DANGER. IF THERE IS ANY DOUBT ABOUT THE SEVERITY OF ANY INJURY, THE OFFICER SHALL TAKE THE YOUTH TO THE DESIGNATED HEALTH AUTHORITY. IN THE EVENT THE DESIGNATED HEALTH AUTHORITY IS NOT IMMEDIATELY AVAILABLE, THE OFFICER SHALL TRANSPORT THE YOUTH TO THE JACKSON MEMORIAL HOSPITAL EMERGENCY ROOM.*

> In the event a youth is injured and medical treatment is required the Superintendent or designee shall be immediately notified.[29]

By removing the need to obtain prior approval and by encouraging JDOs to conduct visual assessments, call 9-1-1 and issue Code Whites as need be, DJJ should not have a repeat of the failures that occurred with Omar Paisley. The fact that these procedures were in effect during the Eric Perez incident underscores the need for DJJ to hire JDOs who have the intelligence and ability to exercise good judgment in situations such as these.

B. <u>Hiring of Juvenile Detention Officers</u>

The job description for a Juvenile Detention Officer posted on the website of the Department of Juvenile Justice provides that it is "a highly responsible position in the criminal justice system [and] the employee is expected to perform all duties in the optimum responsible manner."[30] The duties and responsibilities also, in part, dictate that a Juvenile Detention Officer:

- Ensures the safe and secure custody of all assigned youth while ensuring that all youth are provided their constitutional rights with special concerns for legal, medical and mental health issues. Uses security and emergency equipment to ensure the safety and security of detained youth and facility.
- Follows policies and procedures for the safety and security of detained youth, staff and the public.[31]

In this regard, the DJJ website reveals the basic requirements for a person seeking to become a JDO. Each applicant must:

- Be at least 19 years of age;
- Be a high school graduate or equivalent;

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[29] Facility Operating Procedure FOP#9.07
[30] http://www.djj.state.fl.us/employment/job-descriptions
[31] Id.

- Pass a criminal background check; and
- Successfully complete a drug and background screening.

Effective July 1, 2012, the top ranking applicants who meet these preliminary eligibility requirements are now required to take and pass an Ergometrics Impact Assessment and Training Test. This test is used by DJJ to measure each applicant's overall suitability and adaptability for working with juvenile offenders. Applicants who obtain satisfactory test scores are then required to undergo officer training.

Phase One is workplace training and consists of 120 hours of certification training at a detention center. Phase Two of the training is done at the academy. Among other things, the training of JDOs includes:

a) CPR/First Aid/AED [Automated External Defibrillator] training
b) Mental health and substance abuse
c) Suicide [susceptibility] recognition, prevention and interventions[32]

Upon obtaining appropriate certification, the applicant becomes a DJJ Detention Officer I. Juvenile Detention Officers must also complete a required 24-hours annual in-service training after completing certification training. The mandatory training topics that must be completed each year include, among other things, all three items above.[33] We note that although JDOs are "certified", unlike their counterparts in the adult detention system (the Correctional Officers), JDOs are not sworn law enforcement officers. With so much training focused on the health and well being of our detained youth, there is no reason for JDOs to fail to act when they observe detainees in distress. Even if the medical condition is beyond their training or capabilities, they have to exercise good judgment and know when to call for help. We hope that the recently enacted Ergometrics Training will assist in identifying the Detention Officers who will do just that and weed out those who would be like the ones who failed to act appropriately in the Perez case.

C. Training of Correctional Officers

All inmates housed in adult detention facilities are under the supervision of Correctional Officers (COs). The Correctional Officers are sworn law enforcement officers who receive their

[32] Miami-Dade Regional Juvenile Detention Center Facility Operating Procedure FOP #:1.19
[33] Id., FOP#:1.20

initial training at the police academy. Training at the academy includes First Responder Training. In fact, to satisfactorily complete the academy, candidates must pass the certification test for First Responders. A **Certified First Responder** is a person who has completed a course and received certification in providing pre-hospital care for medical emergencies. First responder courses cover cardiopulmonary resuscitation (CPR), automated external defibrillator (AED) usage, spinal and bone fracture immobilization, oxygen and, in some cases, emergency childbirth as well as advanced first aid. Correctional officers in detention facilities may be called upon to provide first responder assistance which may include providing CPR, bandaging up wounds or otherwise getting someone stable, pending the arrival of Fire Rescue or other Emergency Medical Technicians. Upon obtaining certification, Correctional Officers are required to take regular or refresher courses such as Mandatory In-Service Training, at a minimum, every four (4) years.

In addition to these mandatory refresher courses required of all Florida correctional officers, as the result of a series of recommendations from a predecessor grand jury and another grand jury report, correctional officers in Miami-Dade County receive additional specialized training.[34] This specialized training is designed to teach officers about suicide prevention as well as educate them about signs and symptoms of mental illness and other medical conditions. Moreover, even though some inmates have a history of faking symptoms and malingering, Correctional Officers are trained to act "based on what you see and what they [the inmates] say." Whether the CO believes the inmate is malingering is irrelevant. The CO must provide "unimpeded access to medical services" if it appears someone is having a medical problem. We previously reported that the West Palm Beach Grand Jury noted in its report that it heard testimony from an officer on duty that she overheard the supervisor at the Palm Beach Detention Center state that he did not call 9-1-1 because he thought the youth was faking and he did not want to fill out the extra paperwork."[35] We cannot allow children in our detention facilities to die because Juvenile Detention Officers have a belief that a child is faking an illness. This same mantra that exists for the Correctional Officers should apply for Juvenile Detention Officers as

[34] Final Report of the Miami-Dade County Grand Jury, Spring Term A.D. 2004, Mental Illness and the Criminal Justice System:A Recipe for Disaster / A Prescription for Improvement p. 36.
[35] See footnote 15, infra.

well: act based on what you see and what they [the detainees] say, regardless of your personal beliefs. Doing so might have saved the life of Mr. Perez.

Certified first responders (like Correctional Officers) have more skill than someone who is trained in basic first aid and CPR (like Juvenile Detention Officers). As previously reported herein, present staffing at MDRJDC results in huge blocks of time where neither the Designated Health Authority nor any other health professionals are at the facility. JDOs are always on duty. Due to this reality, we strongly recommend that *all Juvenile Justice Detention Officers should receive First Responder Training as a requirement of their certified training.*

VI. CONCLUSION

In conclusion, we commend the Department of Juvenile Justice for implementing many of the recommendations in the two prior grand Jury reports referred to herein. The grand jury recognizes that thousands of youth pass through Florida's regional juvenile detention centers without incident every year. We are also aware that more than seven (7) years passed between the Paisley and Perez incidents without similar occurrences. Nevertheless, one death was one too many and our predecessors were hoping to prevent a second death. Now that we have reached two deaths we hope the additional recommendations set forth herein and the many innovative steps taken by DJJ will keep us from ever reaching number three.

VII. RECOMMENDATIONS

Based on our investigation and review of the prior reports, we make the following recommendations:

1. The Superintendent at MDRJDC should consider adjusting Maxim's staffing model to:
   a. Consider removing one LPN and adding another registered nurse, and
   b. Adjusting overall schedules to ensure that some medical professional is present on-site every weekend.
2. Alternatively, because the present weekly staffing Matrix and the scheduling of medical professionals at MDRJDC results in no medical professionals at the site on weekends, we recommend that:
   a. A Registered Nurse should be at MDRJDC, at a minimum, five (5) hours a day, seven days a week (to ensure the presence of an RN on-site every weekend);

b. All Juvenile Justice Detention Officers should receive First Responder Training as a requirement of their certified training; and
c. Whenever medical professionals are not present at MDRJDC, Juvenile Detention Officers certified in First Responder Training should be on duty.

3. The Superintendent of MDRJDC should ensure that all DJJ Officers are following procedures for the provision of medical services to detainees at the facility.
4. We join the West Palm Beach Grand Jury in its recommendation that the Florida Legislature amend Florida Statute, Chapter 827.01, to define child as any person under the age of 18 years old or any person being held in the custody of the DJJ or in the custody of any of the DJJ's contracted program providers.
5. We recommend that the newly implemented Ergometrics Testing used to screen applicants seeking jobs as Juvenile Detention Officers also be used as part of the job evaluation process (at least every 12-18 months) for existing JDOs.
6. Although the data provided by DJJ indicates that "on average" this is already being done, we recommend that DJJ policies and Facility Operating Procedures provide that any detainee complaining of a non-emergency medical condition shall be seen by a medical professional within thirty-six (36) hours.
7. We recommend that DJJ and the Superintendent of the various detention centers impose appropriate disciplinary action against any Juvenile Detention Officer who fails to follow procedures ensuring the provision or delivery of medical services to detainees at juvenile detention facilities, even if that failure to act does not result in the death of a detainee.
8. We further recommend that all detainees complaining of physical illness undergo a physical examination by a medical professional.

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
ABRAHAM JACKSON MPAKA	First Degree Murder Burglary With Assault or Battery Therein / While Armed	True Bill
LIONEL JOSEPH SAINT-NELUS	First Degree Murder Burglary With Assault or Battery Therein While Armed	True Bill
MANUEL DE JESUS ACOSTA	First Degree Murder	True Bill
JULIAN GONZALEZ	First Degree Murder Aggravated Assault With a Firearm Aggravated Assault With a Firearm	True Bill
ROBERTO LUIS GARCIA	First Degree Murder Kidnapping / With a Weapon Firearm or Aggravated Battery Robbery / Carjacking Aggravated Battery / Deadly Weapon	True Bill
RAUL ALFONSO TREJO MARTINEZ	First Degree Murder Carrying a Concealed Firearm	True Bill
ANDREW JEROME CHARLES	Robbery / Armed / Firearm or Deadly Weapon Robbery / Carjacking / Armed	True Bill
KENNY DAVIS	First Degree Murder	True Bill
AMADEO VALLS	First Degree Murder Burglary / Armed	True Bill
JOSEPH DANIEL RICHER	First Degree Murder / First Degree Felony Murder Attempted Premeditated First Degree Murder of a Law Enforcement Officer Murder / Premeditated / Attempt / Deadly Weapon or Aggravated Battery	True Bill
CHRISTOPHER SASHA MAXWELL	First Degree Murder Aggravated Assault With a Firearm Aggravated Assault With a Firearm Burglary With Assault or Battery Therein/ While Armed Sexual Battery / Firearm / Deadly Weapon or Serious Injury	True Bill
(A) MARTIN GALLEGOS, and (B) ANTHONY C. ANDY	First Degree Murder (A&B) Robbery/Carjacking/Armed (A&B) Kidnapping/With A Weapon or Firearm or Aggravated Battery (A&B) Robbery Using Deadly Weapon or Firearm (A&B) Arson First Degree (A only) Human Body / Dead/ Abuse (A only)	True Bill
CLIFFORD BRETT FRIEND	First Degree Murder	True Bill
DARRELL TYRONE SMITH, also known as DARRELL TIRONE SMITH and/or DARRELL SMITH	First Degree Murder Robbery Using Deadly Weapon or Firearm	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
LAZARO BERNABEU	First Degree Murder Kidnapping Burglary With Assault or Battery Therein While Armed Child Abuse/No Great Bodily Harm Child Abuse/No Great Bodily Harm Aggravated Assault With a Firearm Aggravated Assault With a Firearm Aggravated Assault With a Firearm	True Bill
DEMARCUS ANTWAN ALEXANDER	First Degree Murder Robbery Using Deadly Weapon or Firearm	True Bill
KIT DURANT	First Degree Murder	True Bill
GEORGE LEVETT WILLIAMS, JR.	First Degree Murder Child Abuse/Aggravated /Great Bodily Harm/Torture	True Bill

ACKNOWLEDGMENTS

Nine months ago, twenty-one randomly selected individuals were brought together to form the Miami-Dade County Grand Jury, Fall Term 2011. These jurors, initially separated by age, ethnicity and cultural diversity, were able to unify as a group to form a motivated team. The experience resulted in a greater knowledge and lifelong respect and appreciation for our judicial system.

It was an honor to serve on the Miami-Dade County Grand Jury and encourage our fellow citizens to participate in this important civic duty when our local government calls them to serve. We are also grateful for having the opportunity to be an influential part of the judicial process. We would like to take this opportunity to express our heartfelt thanks to the following, who have all managed innumerable duties with a cheerful and friendly attitude:

- Honorable Judge Gisela Cardonne Ely, who not only stressed the importance of serving on a grand jury, but also the significance of being involved in the community.
- Honorable Judge Maria M. Korvick, for standing in when Judge Cardonne Ely was unavailable.
- State Attorney Katherine Fernandez Rundle, for her advice, commitment and years of service to the Miami-Dade County community and its judicial system.
- Chief Assistant State Attorney Don Horn, for his professionalism, dedication and support. His endless knowledge and guidance not only educated us but made our service a truly rewarding experience. Our deepest thanks for making our job easier.
- Rose Anne Dare, who flawlessly took care of all administrative details for each and everyone of us. Her professionalism and skills made our task easier to perform.
- Nelido Gil, our Bailiff, who every day greeted us with a smile, served tirelessly and made our days as jurors run as smoothly as possible. His ability to keep us in good spirits was definitely appreciated by all.
- Our court reporters, for their professionalism and commitment.
- To those witnesses and experts who took time to come before us and answered all of our questions and concerns, we also thank you.
- To the detectives and other law enforcement professionals who appeared before us for their obvious dedication to their job.
- To Susan Dechovitz, Assistant State Attorney, for her professionalism and enthusiasm.

Our task was difficult and our journey through the judicial system was at times disturbing, frustrating, surprising and enlightening. Ultimately, despite the personal and professional sacrifices made by each of us, it was an experience we will never forget. It has truly been a privilege and honor to serve our community.

Respectfully submitted,

Nancy Berwick, Foreperson
Miami-Dade County Grand Jury
Fall Term 2011

ATTEST:
Carmelia Bain
Clerk

Date: July 25, 2012