DEPARTMENT OF JUVENILE JUSTICE
OFFICE OF THE INSPECTOR GENERAL
BUREAU OF INVESTIGATIONS

REPORT OF INVESTIGATION

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BRANCH: DETENTION SERVICES

MIAMI-DADE REGIONAL JUVENILE DETENTION CENTER

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INVESTIGATION CONDUCTED BY: **INVESTIGATIONS COORDINATOR GERARD WARD**
INSPECTOR SPECIALIST RICK BODNAR, JR.
INSPECTOR SPECIALIST TRACEY SHEARER
INSPECTOR SPECIALIST RUBEN HERNANDEZ
INSPECTOR SPECIALIST REGGIE MCNEILL

DIRECTED BY: _____
BRIAN A. DONALDSON,
CHIEF OF INVESTIGATIONS

APPROVED BY: _____
ROBERT A. MUNSON,
INSPECTOR GENERAL

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I. EXECUTIVE SUMMARY

On September 1, 2015, Superintendent Steve Owens, Miami-Dade Regional Juvenile Detention Center (Miami-Dade RJDC) notified the Department of Juvenile Justice (DJJ) Office of Inspector General (OIG) Central Communications Center (CCC) that on August 31, 2015, while at the hospital, youth [redacted] went into cardiac arrest and passed away *(Exhibit 1)*. The youth had been transported to the hospital after he was vomiting and complained of nausea. The initial report showed the youth was involved in a physical altercation in Module 9 on August 30, 2015, and later that day, complained of soreness to his body.

The OIG initiated an investigation into the circumstances surrounding this incident to determine if all rules, policies, and procedures were followed. Particular attention was directed towards the supervision of youth and the medical care for youth [redacted], as well as other related procedures and practices deemed relevant to the investigation. To assist in illustrating this incident, a timeline is attached as *Exhibit* 2.

The investigation addressed the following allegations:

Allegation #1: Improper Supervision - JDO Boris Valcin and JDO Antwan Johnson failed to properly supervise youth in Module 9, prior to numerous youth assaulting youth [redacted].

Allegation #2: Improper Supervision, Improper Conduct, Falsification - JDOS Stephen Bronson, JDOS Gabriel Carter, JDOS Shatara Chisolm, JDOS Jeremy Dollard, JDOS Shannon Grant, JDO I Utanda Green, JDOS Marquise McEady, JDO II Demetrius Randolph, JDOS Duviel Rosello, JDOS Cheryl Wallace, JDOS Joshua Washington, and JDO II Michael Young improperly supervised youth [redacted] while he was in medical confinement in the Intake/Release Office (IRO) and failed to properly document youth [redacted] confinement. JDO Young falsified 10-minute checks.

Allegation #3: Medical Neglect - Licensed Practical Nurse (LPN) Peter Beckford and LPN Thomas Adams failed to follow the established medical procedures/protocols regarding the health care provided to youth [redacted].

Allegation #4: Improper Conduct - JDOS Duviel Rosello and JDOS Joshua Washington acted improperly by not immediately transporting youth [redacted] to the hospital after Nurse Adams directed he be taken to the hospital.

Allegation #5: Improper Conduct - Superintendent Steve Owens, Assistant Superintendent Ell Fance, Assistant Superintendent Samuel Thelon, and JDOS Stephen Bronson failed to take appropriate action after becoming aware of an incident involving youth [redacted] and his subsequent medical confinement.

Based on documents reviewed and interviews, there is sufficient evidence to prove Juvenile Detention Officer (JDO) Antwan Johnson and JDO Boris Valcin failed to properly supervise youth on Module 9 on August 30, 2015. The video surveillance revealed that the youth were allowed to walk freely in the dayroom, Johnson and Valcin did not observe all of the youth as required and were not strategically positioned at the time other youth assaulted youth [redacted]. While the video surveillance showed both officers responded to defuse the situation once the assault began, there was a lack of supervision prior to this time. Therefore, the allegation of Improper Supervision against Johnson and Valcin is **SUSTAINED**.

There was also sufficient evidence to prove that former JDO I Utanda Green, former JDO II Demetrius Randolph, JDO Supervisor (JDOS) Joshua Washington, JDOS Shatara Chisolm, and former JDO II Michael Young failed to conduct 10-minute checks and failed to properly supervise youth [redacted] while he was in medical confinement. *[Inspector's Note: Young resigned on February 22, 2016.]* Additionally, there is sufficient evidence to prove JDOS Gabriel Carter, JDOS Jeremy Dollard, JDOS Shannon Grant, former JDOS Marquise McEady, JDOS Cheryl Wallace, and Washington failed to ensure these checks were conducted. There was no visual observation report (VOR) completed by Washington, Green, or Randolph and there were sporadic and inconsistent checks during the shifts these officers were assigned. Chisolm and Young failed to conduct several 10-minute checks during their shift, including one, resulting in a 22-minute gap in supervision. McEady, Grant, Wallace, and Washington failed to note these discrepancies during their reviews of the confinement report and did not correct the problem. Therefore, the allegations of Improper Conduct and Improper Supervision against Carter, Chisolm, Dollard, Grant, Green, McEady, Randolph, Wallace, Washington, and former JDO II Young are **SUSTAINED**.

Neither JDOS Stephen Bronson nor JDOS Duviel Rosello responded to youth [redacted] room while he was confined in the Intake/Release Office (IRO) and had no reason to question the reviews conducted by other supervisors; therefore, they are **EXONERATED** of alleged Improper Conduct and Improper Supervision.

During the investigation and prior to his resignation on February 22, 2016, JDO II Young admitted to falsifying the VOR, therefore, the allegation of Falsification against him is **SUSTAINED**.

As there was no specific policy requiring that supervisors ensure 10-minute checks were conducted; only a facility operating procedure providing general guidance, this was determined to be a **POLICY DEFICIENCY**.

There was sufficient evidence to prove Nurse Peter Beckford and Nurse Thomas Adams failed to follow nursing protocol. Both nurses indicated they suspected a possible head injury to youth [redacted]; however, continuous assessments and required notifications to the medical doctor were not made. Therefore, the allegation of Medical Neglect against both individuals is **SUSTAINED**. It is recommended that the DJJ Office of Health Services (DJJ/OHS) review this issue and refer the matter to the Florida Board of Nursing to determine whether Nurse Beckford and Nurse Adams complied with the Nurse Practice Act.

There was insufficient evidence to prove or disprove that JDOS Rosello or JDOS Washington acted improperly in transporting youth [redacted] to the hospital. Nurse Adams reported that youth [redacted] experienced initial discomfort when he arrived at the nurse's station, but that he had calmed down. Nurse Adams observed nothing that caused him any concern at the time the youth was in the nurse's station. As there was no policy dictating a specific time frame in which a youth should be transported from the detention center once referred for outside medical care, this was determined to be a **POLICY DEFICIENCY**; therefore, JDOS Rosello and former JDOS Washington are **EXONERATED** of Improper Conduct regarding this allegation. It is recommended DJJ/OHS review this issue and if deemed appropriate, refer the matter to the Florida Board of Nursing to determine if Nurse Adams complied with the Nurse Practice Act. It is also recommended that Detention Services develop a specific policy addressing the appropriate transportation of youth, once they have been referred for outside medical care.

There was also insufficient evidence to prove or disprove that Superintendent Owens failed to perform his duties; however, there was sufficient evidence that Assistant Superintendent Thelon, and JDOS Bronson failed to perform their duties. Each of these staff were aware of the battery on youth [redacted], a criminal act, but failed to notify law enforcement. Furthermore, as youth [redacted] had stated he wanted to kill the other youth, there was potential jeopardy to both youth [redacted] and the other youth. It is noted that at the time, there was no written requirement to notify law enforcement under these circumstances. Assistant Superintendent Thelon failed to carry out several of his responsibilities, specifically, he did not review supervisor comments on the confinement report and he did not read the Youth Alert Note for youth [redacted]. Reading the note would have alerted Thelon to the requirement that the youth was to be awakened every two hours. In addition, JDOS Bronson failed to perform his duties, as he was aware the evening of August 30, 2015, of the assault on youth [redacted], but he did not relay this information to the nurse. Furthermore, there was sufficient opportunity for Bronson to have at least informed Superintendent Owens of the details when the two of them escorted youth [redacted] to the nurse's station the morning of August 31, 2015. Therefore, the allegation of Improper Conduct is **NOT SUSTAINED** against Owens and is **SUSTAINED** against Thelon and Bronson.

As Assistant Superintendent Fance was not at work in the facility from the time of the assault until after youth [redacted] death, it was determined that he did not act improperly. Therefore, the allegations against him are **UNFOUNDED**.

The circumstances of this case indicate there should be written guidance addressing appropriate notification of law enforcement under certain conditions. Therefore, this is considered to be a **POLICY DEFICIENCY**.

Please refer to the individual Conclusions/Recommendations sections and the Additional Matters section of this report for recommendations to Detention Services.

Youth [redacted] death is currently being investigated by the Miami Dade Police Department as a homicide case under #PD150901326506.

II. INVESTIGATIVE PREDICATE AND BACKGROUND

On September 1, 2015, Superintendent Steve Owens, Miami-Dade Regional Juvenile Detention Center (Miami-Dade RJDC) notified the DJJ OIG CCC, that at 10:45 p.m. on August 31, 2015, while at Holtz Hospital, youth [redacted] went into cardiac arrest and passed away at approximately 11:05 p.m. *(Exhibit 1)*. According to the caller, the youth had been transported to the hospital around 4:30 p.m. after he was vomiting and complained of nausea to the facility nurse. *[Inspector's Note: Video surveillance reviewed during the investigation revealed that youth [redacted] did not leave the center until around 4:57 p.m.]* It was subsequently determined that previously on August 30, 2015, youth [redacted] was involved in a physical altercation on Module 9 and later that day, complained of soreness to his body. *[Inspector's Note: Video surveillance revealed that shortly after the youth returned to the module from the dining hall, approximately 12-16 youth either directly assaulted youth [redacted] or participated in some manner.]*

The OIG initiated an investigation into the circumstances surrounding this incident to determine if all rules, policies, and procedures were followed. The investigation also addressed related procedures and practices deemed relevant to the investigation.

Specific areas investigated included whether:

- Direct care staff in Module 9 properly supervised the youth prior to the incident involving youth [redacted];
- Direct care staff, to include supervisors, properly supervised youth [redacted] while he was in medical confinement in the Intake Release Office and properly documented the required 10-minute checks;
- Nursing staff followed protocol in the health care provided to youth [redacted];
- Direct care staff, to include supervisors and management, transported youth [redacted] to the hospital in an appropriate manner, and
- Facility management took appropriate action after becoming aware of the incident involving youth [redacted].

The Miami-Dade RJDC is a 126-bed, hardware secure facility that serves youth detained by various circuit courts. It is located in Circuit 11, Miami, Miami-Dade County, Florida. Youth are detained pending adjudication, disposition, or placement in commitment facilities.

III. MATTERS INVESTIGATED

Allegation #1: Improper Supervision

Synopsis - JDO Boris Valcin and JDO Antwan Johnson failed to properly supervise youth in Module 9 prior to numerous youth assaulting youth [redacted]. *[Inspector's Note: Video surveillance coverage of the incident revealed no deficiencies in the manner in which Valcin and Johnson reacted to the situation once it began.]*

Applicable Statutes/Rules/Policies/Guidance

Chapter 63G-2.019, Security, Florida Administrative Code (F.A.C.) – This rule addresses security requirements for detention center operations. Under Paragraph (6), Youth Movement, it states that officers shall remain alert while they interact with youths and be aware of the location and movement of all youths assigned to their supervision at all times. Paragraph (10), Staff Positioning, states that officers will position themselves strategically so as to have optimum sight and sound supervision.

Miami-Dade RJDC Facility Operating Procedure 1.09, Standards of Conduct – Under Paragraph E of Procedures, it states that staff will always provide for the youth's basic needs and "will not, through inaction or inattention, allow these needs to remain unmet." Furthermore, under Paragraph H, DMS Standards of Conduct, this procedure states that "failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence.

Miami-Dade RJDC Facility Operating Procedure 8.04, Youth Movement, Counts, and Supervision under Paragraph A. Effective Supervision, this procedure states that the primary function of the JDO is to provide supervision, control, and custody of youth. It further states that all youth will be in the sight of at least one JDO at all times. Officers shall focus on effective positioning for optimum sight and sound supervision. Under Paragraph D. Arrival at Living Module, it states, "when youth and Officers arrive at the living Module, youth are to immediately be directed to stand near their room doors . . . Youth shall never be allowed to walk freely around the module upon entry as this makes proper supervision extremely difficult."

Record Reviews - During the course of the investigation, unless otherwise noted, the investigative team reviewed the following records:

Protective Action Response (PAR) Report for youth [redacted] (*Exhibit 3*) - The PAR report written by JDO Johnson states he responded to a physical altercation involving several youths and youth [redacted] in Module 9.

PAR Report for youth [redacted] (*Exhibit 4*) - The PAR report written by JDO Valcin states he responded to an incident in Module 9 in which several youth were assaulting youth [redacted].

Excerpts from the Module 9 Logbook (*Exhibit 5*) – This logbook reflects a 5:25 p.m. entry on August 30, 2015, indicating a Code Blue was called after youth [redacted] was involved in a physical altercation with several youth. *[Inspector's Note: A Code Blue indicates staff assistance is needed immediately.]*

Video Surveillance of Module 9 from Camera 126 and Camera 128, and selected digital images (*Exhibits 6, 7, and 8, respectively*) – This video surveillance shows the assault on youth [redacted] by other youth in Module 9 and JDOS Johnson's and Valcin's response to the incident. The video also shows JDOS Johnson and Valcin attempting to remove youths who were assaulting or surrounding youth [redacted].

Video Surveillance of Module 9 from Camera 125 and selected digital images (*Exhibits 9 and 10, respectively*) – A review of earlier video surveillance of the module revealed that JDOS Johnson and Valcin did not maintain constant visual observation of the youth while in Module 9. Furthermore, when the incident began, both officers were standing only several feet from each other and were positioned on the opposite side of the dayroom from the incident and the majority of the youth.

Video Surveillance of Module 9 from Camera 126 selected digital images (*Exhibits 11 and 12, respectively*) – A review of even earlier video surveillance revealed that the youth entered Module 9 around 5:33 p.m. on August 30, 2015, and proceeded to mingle around the blue chairs in the center of the dayroom. There did not appear to be any indication that staff were directing the youth to stand in front of their doors, per facility operating procedures.

Miami Dade RJDC Incident Report 201508300020 (*Exhibit 13*) - This report reflects that the entries by JDO Johnson and JDO Valcin includes the same information as in their PAR reports.

Interviews - Unless otherwise noted, the investigative team conducted the following interviews, which were sworn and electronically recorded. As there remains an open criminal investigation by the Miami-Dade Police Department, into the assault on youth [redacted], no youth interviews were conducted during the OIG investigation.

JDO Ronnie Mathis (Witness)
Date of Interview: September 22, 2015, and October 6, 2015

JDO Mathis was working the 7 a.m. to 3 p.m. shift on August 30, 2015, and had contact with youth [redacted]. He stated the following: There was a fight between some other youth on the recreation field. A Code Blue was called and staff started securing all the youth in the module, when youth [redacted] got upset and chastised the other youth in general. One of the (unidentified) youth asked youth [redacted], "Who are you talking to?" and youth [redacted] responded, "I'm talking to you." Mathis stated he could not recall the identity of the youth but maintained it was not youth [redacted]. *[Inspector's Note: Youth*

[redacted] was the youth who initially assaulted youth [redacted] later that evening in Module 9. The investigative team was trying to ascertain whether there were any indicators of a brewing confrontation between youth [redacted] and youth [redacted] that might have been overlooked. See Exhibit 14 for a related incident report.]

Mathis further stated he later counseled youth [redacted] and the youth said he was okay. He briefed JDO Johnson and another staff whose name he could not recall, about the incident and the verbal altercation between youth [redacted] and the other youth, telling the staff to be careful. He said he was concerned youth [redacted] would get into a physical altercation with the other youth he had exchanged words with, because he might have felt the other youth was challenging him. Mathis was unaware of a specific motive as to why almost an entire module of youth would target and assault youth [redacted].

JDO Antwan Johnson (Subject)
Date of Interview: September 16, 2015

JDO Johnson was working on the 3 p.m. to 11 p.m. shift on August 30, 2015, assigned to the module. The video surveillance also confirmed he was one of the two direct care staff working on Module 9 that evening. He stated and/or confirmed the following: On the evening of August 30, 2015, he and JDO Valcin were assigned to Module 9, where there were approximately 20 youth in the module. During shift change, JDO Mathis advised there had been some issues between youth [redacted] and other youth, but he did not expand on those issues. According to Johnson, the youth on the module did not say anything, indicating they had a problem with youth [redacted]. When he came on duty in the module, he spoke with youth [redacted], who said he was okay.

Johnson further advised there was a verbal altercation that occurred in the cafeteria while youth [redacted] was going to get another milk, and he told him to have a seat. The youth cursed at him and former JDOS Dollard counseled youth [redacted]. Nothing else transpired during this time. *[Inspector's Note: The verbal altercation was not discernible in video surveillance of the cafeteria. See Exhibits 15 and 16.] [Inspector's Note: Former staff Dollard declined to be interviewed.]*

According to Johnson, when the group returned from the cafeteria and re-entered the module, he made sure everyone was on the module, then he put a barrel of clothing and shower supplies into the closet. When asked about the policy regarding re-entering the module, Johnson initially said the youth were to have a seat in the module, but later admitted he read in policy that they were supposed to stand in front of their doors, but he told them to have a seat. Johnson said the youth had been in the dayroom before going to the dining hall and he had them return to their seats when they re-entered the module.

Johnson admitted that when he entered the closet to put away the clothing and supplies, he did not have visual observation of the dayroom where the youth were located. After reviewing the video surveillance of the area during the interview, he conceded JDO Valcin

did not have visual observation of at least two youths at that time. While he fluctuated, Johnson ultimately admitted the youth were not under constant visual observation. When asked if Valcin and he positioned themselves strategically for optimum sight and supervision of the youth per the secure detention rule, he replied that he thought he had; however, he did not know why Valcin came over to the side of the dayroom where he was located. Johnson stated that Valcin should have stayed where the youth were located while he put the clothes into the closet. Johnson claimed he was able to observe some of the youth while he was putting the barrel in the closet. He said, for example, he noticed youth [redacted] pull his chair closer to the television. *[Inspector's Note: The video was reviewed with Johnson; however, there was no indication that youth [redacted] attempted to move his chair.]*

Johnson further stated that when he first noticed the altercation, he called a Code Blue and started to move towards the area. He observed youth [redacted] and a youth by the first name of "[redacted]" "square off." As evidence of his claim that he saw the incident at the onset, he said his incident report reflected that youth [redacted] and youth [redacted] engaged in a physical altercation. *[Inspector's Note: This statement not only conflicts with Johnson's testimony that youth [redacted] and "[redacted]" squared off, but a review of Johnson's written reports showed he did not mention youth [redacted] in the reports. Johnson's claim is that he was able to respond once the incident started. Per the video surveillance, the incident began with youth [redacted] assault on youth [redacted]. If Johnson had seen the beginning of the incident, one would expect him to have properly identified youth [redacted] as the initial assailant.]* When pressed as to whether staff were positioned strategically, Johnson said he thought he was, but added he had no control over JDO Valcin. Johnson said at the time of the incident, he was not aware of where Valcin was or what he was doing. He was the more senior officer (eight years of experience) and Valcin had just graduated from the academy. He said he followed all the procedures and policies that day and thought there was sight and sound supervision of the youth on the module.

Upon being challenged with several discrepancies in his testimony and his written reports, Johnson claimed he tried his best to de-escalate the situation. He admitted the problem was with the supervision; that when the group first entered the module, some youth were walking around freely. He further admitted there was not complete visual observation of all the youth.

Former JDO Boris Valcin (Subject)
Date of Contact: September 18, 2015

JDO Valcin was working on the 3 p.m. to 11 p.m. shift on August 30, 2015, assigned to the module. Video surveillance confirmed he was one of the two direct care staff working on Module 9 that evening.

On September 18, 2015, former JDO Valcin agreed to be interviewed on September 22, 2015. *[Inspector's Note: Valcin transferred from Miami-Dade RJDC to Broward RJDC and he resigned from the Department on September 11, 2015, providing no specific reason for his resignation. See Exhibit 17.]* Valcin failed to show up for the interview and shortly after the scheduled time of the interview, he called and declined to be interviewed for this investigation.

Conclusions/Recommendations - Based on documents reviewed and interviews, there is sufficient evidence to prove JDO Antwan Johnson and JDO Boris Valcin failed to properly supervise youth on Module 9 during the evening of August 30, 2015. Video surveillance revealed that the youth were allowed to walk freely in the dayroom immediately upon their return from the cafeteria; that there were periods when neither Johnson nor Valcin were visually observing some of the youth; and that Johnson and Valcin were not strategically positioned when the assault on youth [redacted] began. Johnson admitted the youth were walking around freely and there was not complete visual observation of all the youth. Valcin, who had previously resigned, declined to be interviewed. Therefore, the allegation of Improper Supervision against Johnson and Valcin is **SUSTAINED**. *[Inspector's Note: As to Johnson's and Valcin's response to the incident once it began, video surveillance indicates that both officers responded appropriately and attempted to defuse the situation and remove youth [redacted] from further harm. Both are PAR certified and training certificates are available upon request.]*

Allegation #2: Improper Supervision, Improper Conduct, Falsification

Synopsis – JDOS Stephen Bronson, JDOS Gabriel Carter, JDOS Shatara Chisolm, JDOS Jeremy Dollard, JDOS Shannon Grant, JDO I Utanda Green, JDOS Marquise McEady, JDO II Demetrius Randolph, JDOS Duviel Rosello, JDOS Cheryl Wallace, JDOS Joshua Washington, and JDO II Michael Young improperly supervised youth [redacted] while he was in medical confinement in the Intake Release Office (IRO) and failed to properly document youth [redacted] confinement. It is also alleged that JDO Young falsified checks.

Applicable Statutes/Rules/Policies/Guidance

Chapter 63G-2.018, Documentation/Management Systems, Florida Administrative Code (F.A.C.) – This rule provides for the management of documents, to include confinement reports. Paragraph (1) states that all documents, including information entered into Juvenile Justice Information System (JJIS) and/or Facility Management System (FMS) represent official records. Failure to document required information, falsification of information, or failure to properly retain written

documents may result in disciplinary action up to and including dismissal. Paragraph (3) addresses logbooks, and specifically subparagraph (e) states the supervisor(s) shall review the living area logbooks daily.

Chapter 63G-2.019, Security, Florida Administrative Code – This rule addresses security requirements for detention center operations. Paragraph (7), Visual Observation Report (VOR), states that when a youth is confined to a room, whether for sleeping or other reasons, officers shall conduct visual observations to ensure safety and security. It further states the observations shall be documented to include the time of the observation and the initials/identification of the officer completing the observation. Electronic documentation is acceptable for facilities using electronic cell check systems. Subparagraph (d) specifically states, "If an officer, in the course of completing observations, is unable to see any part of a youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence." *[Inspector's Note: Chapter 63G-2.014, Definitions, Florida Administrative Code, Paragraph (62) provides that the interval for checks for standard supervision not exceed 10 minutes.]*

Chapter 63G-2.022, Behavior Management and Disciplinary Treatment, Florida Administrative Code – This rule provides for the use of an established behavior management system, which promotes safety, respect, fairness, and protection of rights within the facility. Paragraph (4), Confinement, states the use of confinement shall be monitored by the Superintendent or designee, and it requires that a Juvenile Detention Officer supervisor evaluate and document the youth's status, at a minimum, every three hours to determine if the continued confinement of the youth is required. Subparagraph (g) further states, "A confinement report shall be reviewed by the JDOS as soon as possible, but no later than two hours of the youth's confinement. The review shall include documentation of the allegations and the youth's opportunity to grieve (appeal) the confinement placement. The JDOS shall evaluate and document the youth's status, at a minimum, every three hours to determine if the continued confinement of the youth is required."

Chapter 60L-36.005, Disciplinary Standards, Florida Adminstrative Code – This rule sets forth the minimal standards of conduct that apply to all employees in the State Personnel System. Under Paragraph (3)(a) Poor performance, it states "Employees shall strive to perform at the highest level of efficiency and effectiveness; they shall do more than "just get by." Paragraph (3)(b) Negligence, states "Employees shall exercise due care and reasonable diligence in the performance of job duties."

DJJ Detention Services Directive – This directive was sent on March 12, 2015, to all detention superintendents to be implemented immediately. It states the following:

1. Youth are instructed to inform a JDO immediately when they have health complaints or need medical attention. The JDO will enter the sick call request in the JJIS system in the Electronic Medical Record. If healthcare staff are not on-site, the shift supervisor will review all sick call requests to determine if there is an immediate need. This should occur no later than four (4) hours after the sick call request is submitted by the youth. Each shift

supervisor will note their review (if there is no nurse present) in their notes in their shift report.

2. Start using the term "medical confinement" for any youth who is placed in a room for a medical or sick reasons. If you have such a youth, there will need to be an officer in the area at all times. The check periods would be governed by the current level of supervision. However, the officer will need to speak with the youth a minimum of every 30 minutes. If the youth is sluggish, not answering, sleeping deeply, it may be necessary to get an additional officer and enter the room to check on the youth.

Miami-Dade RJDC Facility Operating Procedure 1.09, Standards of Conduct – This procedure, under Paragraph E of Procedures, states that staff will always provide for the youth's basic needs and "will not, through inaction or inattention, allow these needs to remain unmet." Furthermore, under Paragraph H, DMS Standards of Conduct, this procedure states that "failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence. This paragraph also states falsification of records, documents, reports, logs, or statements constitutes a violation of standards.

Miami-Dade RJDC Facility Operating Procedure 1.15, Shift Change Meeting – This procedure directs under Paragraph A.1., that the off-going shift commander will review with the in-coming shift commander, supervisors, and staff, the names of youth placed in confinement and their current status.

Miami-Dade RJDC Facility Operating Procedure 2.08, Confinement/Trauma Informed Care – While this procedure appears to address confinement primarily as a means to gain immediate control of a situation, to ensure safety and security, or to modify youth behavior, it directs under the Procedures paragraph that "staff shall visually observe the youth every ten minutes or less, unless the youth is on Precautionary Observation (where supervision is either constant or one-to-one) . . ." It further directs that room checks shall be posted outside the door of the room where the youth is confined.

Miami-Dade RJDC Facility Operating Procedure 8.04A. General Supervision/Occupied Rooms/Opening and Closing Doors – This procedure lists medical isolation as one of the general reasons a youth may be in a room. Under a paragraph marked Youth In Confinement, it states, "There are routine situations when one officer alone may open the door to a room in which a youth is confined . . . However, either Master Control or a Shift Supervisor must first be notified prior to the door being opened – or a second officer must be present." Under a paragraph, specifically marked Medical Isolation, it states, "the same guidelines for opening the door for a youth in confinement shall be adhered to when opening the door of a youth in medical isolation."

Miami-Dade RJDC Facility Operating Procedure 8.14, Room Checks – This procedure states in Paragraph A, "When a youth is confined to a room . . . officers shall conduct, at a minimum, ten-minute (10) checks to ensure safety and security. Ten-minute (10) checks shall be conducted using the Silver Guard System." The procedure does allow for an alternate method of

documenting the check on a standard supervision room check form. The procedure further states in this paragraph that failure to complete the check or any falsification of times will result in disciplinary action.

Record Reviews - During the course of the investigation, unless otherwise noted, the investigative team reviewed the following records:

Miami-Dade RJDC Shift Report for August 30, 2015, from 3:00 p.m. to 11:00 p.m. (*Exhibit 18*) – This report reflects that current confinements and their status were discussed with the on-coming staff. *[Inspector's Note: The reason for this discussion would be so the on-coming shift is made aware of any issues and notified of who is assigned to medical confinement.]* In the narrative regarding the physical altercation occurring in Module 9, youth [redacted] is listed as confined; however, in other parts of the report, only youths [redacted], [redacted], and [redacted] are listed as being on medical confinement (*see the Additional Issues section).*

This report also reflects that JDO Green and JDOS Washington were assigned to the Intake Release Office (IRO) during this shift. Washington was listed as the Shift Supervisor. JDOS Stephen Bronson was listed as a supervisor with assigned duties of perimeter checks, modules 4, 7, and 9, medical, and transportation. JDOS Dollard was listed as a supervisor with assigned duties of unannounced PREA checks, point of service, and perimeter checks.

Miami-Dade RJDC Shift Report from 11:00 p.m. August 30, 2015, to 7:00 a.m. August 31, 2015 (*Exhibit 19*) – This report reflects that JDO Green and JDO Randolph were assigned to the IRO during this shift. JDOS McEady was listed as the Shift Supervisor. No other supervisors were listed. The report indicated current confinements and their status were discussed, although there was no indication of who was confined. Neither youth [redacted] first or last name were listed in this report.

Miami-Dade RJDC Shift Report from 7:00 a.m. to 3:00 p.m., August 31, 2015 (*Exhibit 20*) - This report reflects that JDOS Shatara Chisolm and JDO Young were assigned to the IRO during this shift. JDOS Grant was listed as the Shift Supervisor and Assistant Superintendent Samuel Thelon was the Shift Commander. Grant's specific duties were the shift report, Module 2, Central, and the snack program.

JDOS Gabriel Carter was listed as a supervisor with assigned duties of the school program; perimeter check; and Modules 3, 4, and 9.

JDOS Duviel Rosello was listed as a supervisor with assigned duties of the school and lunch program and Modules 3 and 7.

JDOS Cheryl Wallace was listed as a supervisor with the assigned duties of the IRO, Transportation, medical appointments, and evaluations.

The report indicated that current confinements and their status were discussed; however, neither youth [redacted] first or last name were listed in this report.

Miami-Dade RJDC Shift Report for August 31, 2015, from 3:00 p.m. to 11:00 p.m. (*Exhibit 21*) – This report indicated that current confinements and their status were discussed. It showed that youth [redacted] was in medical confinement in Room 160, from 6:15 p.m. August 30, 2015, to 5:15 p.m. August 31, 2015. The report also showed that youth [redacted] was transported to Jackson Memorial Hospital Holtz emergency room by JDO II Ledarius Murphy and JDO I Kendra Hicks at an unspecified time, due to vomiting and nausea.

JDOS Washington is listed as the Shift Supervisor. Bronson was listed as a supervisor, with assigned duties of perimeter checks, transportation, medical, IRO, fire drills, and Modules 2, 3, and 4.

Confinement Report for Youth [redacted] (*Exhibit 22*) – This report reflects that youth [redacted] was placed into medical confinement on August 30, 2015, at 6:15 p.m. by JDOS Washington, and the confinement was approved by Assistant Superintendent Thelon. The report indicated youth [redacted] was placed on medical confinement for "24 hours concussion precaution" per Licensed Practical Nurse (LPN) Peter Beckford, and that the youth had been involved in a physical altercation.

The following staff were listed on the report as completing supervisory reviews of youth [redacted] medical confinement:

- JDOS Washington – 7:43 p.m. and 10:00 p.m., August 30, 2015
- JDOS McEady – 12:05 a.m. and 2:00 a.m., August 31, 2015
- JDOS Wallace – 6:27 a.m., August 31, 2015
- Assistant Superintendent Thelon – 8:00 a.m., August 31, 2015
- JDOS Grant – 8:12 a.m., 12:15 p.m., and 3:33 p.m., August 31, 2015
- JDOS Chisolm – 10:03 a.m., 1:59 p.m., and 5:15 p.m., August 31, 2015

The report indicated that Licensed Mental Health Counselor Ricardo Sardina noted that youth [redacted] was resting at 1:35 p.m., August 31, 2015, and that he was transported to Jackson Memorial's Holtz Children's Hospital around 5:15 p.m., August 31, 2015.

Youth Alert Notes Report for youth [redacted] (*Exhibit 23*) – This report reflects that Nurse Beckford created an alert, indicating that youth [redacted] was placed on Concussions Precautions for 24 hours, and noted the youth should be monitored for "repeated vomiting, dizziness, headache, visual disturbances, seizures, confusion, or unusual drowsiness." The report also stated the youth "should also be awoken if he is sleeping every 2 hours to assess youth's alertness." *[Inspector's Note: Based on a review of the video surveillance (see Exhibit 26), it appears these instructions were not followed, as no staff had contact*

with youth [redacted] from 9:18 p.m. to 11:35 p.m. on August 30, 2015; from 11:44 p.m., August 30, 2015, to 3:41 a.m., August 31, 2015; and from 3:41 a.m. to 6:17 a.m., August 31, 2015. Those staff identified as subjects in this allegation were responsible for ensuring these instructions were followed.]

Excerpts from the IRO Logbook (*Exhibit 24*) – This logbook noted the following relevant entries:

- At 6:15 p.m., on August 30, 2015, JDO Green noted that youth [redacted] was placed on bed rest.
- At 8:24 p.m., Green noted that JDOS Stephen Bronson was en route to the nurse's station with youth [redacted]. *[Inspector's Note: The video surveillance showed JDOS Washington escorted youth [redacted] from his room to the IRO lobby, where JDOS Bronson then escorted the youth to the nurse's station.]*
- At 11:00 p.m., JDO Green and JDO Randolph were on duty in the IRO. Green noted that youth [redacted] was either on medical confinement or bedrest. *[Inspector's Note: The logbook contained the entry "Accepted IRO w/ 1 medical confinement, 1 bedrest, [redacted], 1 1 holding from the JAC..." It is not indicated which youth was on medical confinement and which was on bedrest. It is unknown why two different terms were used.]*
- Sometime between 6:40 a.m. and 6:46 a.m., on August 31, 2015, Green noted that Nurse [Thomas] Adams was in the IRO to see another youth.
- At 7:26 a.m., JDO Young noted that he and JDOS Chisolm accepted the IRO with 3 youth, 1 youth in P.O. (Precautionary Observations) and 2 on bedrest.
- At 7:46 a.m., JDOS Gabriel Carter made an entry indicating he conducted a status check of the area and there were 2 youth on bedrest and one youth in precautionary observations. *[Inspector's Note: A review of the video surveillance showed Carter entered the IRO area at 7:49 a.m. and departed at 7:51 a.m. He did not check youth [redacted] room.]*
- At 8:34 a.m., Young noted that Superintendent Steve Owens and Thelon were en route to medical with youth [redacted].
- At 8:45 a.m., Young noted that Thelon was back in the IRO with 1 youth.
- At 9:13 a.m. Thelon noted that he conducted a status check in the IRO and reviewed the logbook.
- At 12:45 p.m., JDOS Chisolm noted that youth [redacted] used the phone.
- At 3:36 p.m., Green noted that she accepted the IRO with youth [redacted] listed as on bedrest. *[Inspector's Note: Youth [redacted] was listed as on medical confinement, making a distinction between medical confinement and bedrest.]*
- At 3:38 p.m., Green noted that a Code White was called for youth [redacted], who was taken to the nurse's station. Youth [redacted] stated he felt like something was broken in his chest and it was hard for him to breathe. *[Inspector's Note: A Code White indicates a situation requiring immediate medical attention.]*

10 Minute Visual Observation Report (VOR) (*Exhibit 25*) – This report indicates that the first observation entry was made at 7:28 a.m. on August 31, 2015, by staff "Y." *[Inspector's Note: This staff was identified as JDO II Michael Young through a review of the shift report and during interviews. It should also be noted this was the only VOR the Miami-Dade RJDC provided that addressed youth* [redacted] *medical confinement. There was some initial confusion concerning the VOR, as the video surveillance indicated JDO Josue Lambert posted the VOR on the wall, yet Young's initials appeared twice before Lambert's initials. After reviewing the video surveillance several times, the OIG concluded that Young initialed the first two checks when this VOR was still in the IRO office area, and not yet posted. Young then gave Lambert the VOR to post. On December 22, 2015, Young testified that although he could not recall exactly what happened, he concurred that most likely, he initialed this VOR after having checked on youth* [redacted] *around 7:39 a.m. Young returned to the office, initialed the VOR, and then gave it to Lambert to post.]* Subsequent checks were made as follows:

- JDO Young initialed seven of the eight checks conducted until 8:27 a.m. The check at 7:42 a.m. was initialed by JDO Lambert. These eight checks were within the required time frame. The report then showed the youth was out to the nurse until the next checks were initialed by Young at 8:48 a.m. and 8:52 a.m. *[Inspector's Note: The IRO logbook showed that at 8:34 a.m., Superintendent Owens and Assistant Superintendent Thelon were en route to medical with youth* [redacted] *and a late entry in the medical progress notes showed that at 8:40 a.m., youth* [redacted] *was brought to medical complaining of body ache. The video surveillance (Exhibit 26) showed youth* [redacted] *departed the nurse's station at 8:51 a.m., which conflicts with Young's initialed check at 8:48 a.m. The video showed Young entered youth* [redacted] *room around 8:55 a.m., which correlated with his initials on the VOR at 8:52 a.m.]*
- JDO "RM" initialed seven checks beginning at 9:03 a.m. and ending at 10:14 a.m., approximately 11-12 minutes apart. *[Inspector's Note: During a review of the video surveillance, this staff was identified as JDO I Raymond Manaigo. The video also confirmed the checks were conducted by Manaigo; however, the intervals between the checks as measured by the video surveillance time ranged from 3 minutes apart to 15 minutes apart, not 11 to 12 minutes apart as indicated in the VOR.]*
- There were no checks marked for a 32-minute period between 10:14 a.m. and 10:46 a.m. *[Inspector's Note: The video surveillance showed various staff looked into youth* [redacted] *room during this period, with the longest period without any check being a 17-minute gap between 10:31 a.m. and 10:46 a.m.]*
- JDO "AG" initialed nine checks beginning at 10:46 a.m. and ending at 12:26 p.m., with two of the checks being late by five minutes or more. During this period, JDOS Chisolm initialed one check at 10:55 a.m. *[Inspector's Note: During a review of the video surveillance, this staff was identified as JDO I Arthur Glanville. The video surveillance showed Glanville and other personnel conducting checks, but not recording them on the VOR. These intermediate checks resulted in the greatest*

gap of 15 minutes between checks during this period. JDO Glanville, along with JDO Manaigo, was listed as being in a training status, with Young and Chisolm as the assigned officers for the IRO.]

- JDO Manaigo initialed two checks at 12:38 p.m. and 12:52 p.m. *[Inspector's Note: The video surveillance showed Manaigo escorted youth [redacted] to the IRO lobby at 12:42 p.m. and returned him to his room at 1:01 p.m. During this period, youth [redacted] was with Manaigo, therefore, these checks would have been appropriately recorded.]*
- There were no checks marked for the 31 minutes between 12:52 p.m. and 1:23 p.m. *[Inspector's Note: The video surveillance showed youth [redacted] was with Manaigo, until he was returned to his room at 1:01 p.m., so the actual gap between checks was 22 minutes.]*
- JDO Glanville initialed a check at 1:23 p.m. and 12 subsequent checks until 3:24 p.m. *[Inspector's Note: The video surveillance showed Glanville conducted what appeared to be 15 checks of youth [redacted] room during this period, with most of the checks conducted within the 10-minute interval. Several checks appeared to exceed the interval by a minute or two.]*

Digital Images obtained from video surveillance (*Exhibit 26*) - The video surveillance of the IRO area was reviewed from the time youth [redacted] was taken there (around 6:16 p.m., August 30, 2015) to the time he was escorted to the nurse's station (around 3:43 p.m., August 31, 2015). *[Inspector's Note: Due to its size, the video surveillance coverage is maintained in an electronic file.]* From this video surveillance, several digital images were obtained and included in this exhibit in order to objectively assess who had contact with youth [redacted] and at what times. Throughout this investigative report, there are numerous comparisons made between what was written on documents, such as the confinement report and the VOR, and what was actually recorded by the video surveillance. As previously noted, these comparisons reflect the following:

- There were three periods during which the nurse's instructions were not followed with respect to contacting youth [redacted] every two hours;
- Checks of youth [redacted] during the night of August 30, 2015 and in the early morning hours of August 31, 2015 were sporadic and inconsistent;
- JDO Young initialed checks that are not supported by the video; and
- At 8:58 p.m. on August 30, 2015, JDOS Dollard escorted youth [redacted] to his room. Dollard also checked on youth [redacted] at 11:35 p.m.

Dismissal Letters (*Exhibits 27, 28, and 29*) – Regional Director Gladys Negron provided copies of three letters she sent on September 4, 2015, dismissing JDOS Washington, JDOS Dollard, and JDOS McEady, each of whom were on Select Exempt Service status. The letters stated the dismissals were as a result of violation of rules. *[Inspector's Note: Dr. Negron explained that Washington had been assigned to the IRO on August 30, 2015; McEady documented in the Confinement Report that he observed youth [redacted] when*

video surveillance revealed he did not conduct a check; and Dollard was in the IRO, but failed to check on youth [redacted].]

Proposed Dismissal of Demetrius Randolph (*Exhibit 30*) – Regional Director Negron provided a copy of a letter sent on September 4, 2015, proposing dismissal of JDO Randolph under "extraordinary circumstances." The letter stated JDO Randolph failed to conduct required ten-minute checks for a youth who was confined to his room from August 30-31, 2015. *[Inspector's Note: Director Negron later confirmed that Randolph had been dismissed.]*

Proposed Dismissal of Utanda Green (*Exhibit 31*) – Regional Director Negron provided a copy of a letter sent on September 4, 2015, proposing dismissal of JDO Green under "extraordinary circumstances." The letter stated JDO Green failed to conduct required ten-minute checks for a youth who was confined to his room from August 30-31, 2015. *[Inspector's Note: Director Negron later confirmed that Green had been dismissed.]*

Interviews - Unless otherwise noted, the investigative team conducted the following interviews, which were sworn and electronically recorded.

JDO I Author Glanville (Witness)
Date of Interview: October 5, 2015

The shift report for 7 a.m. to 3 p.m., August 31, 2015, noted that JDO Glanville was assigned to the IRO. Video surveillance confirmed his presence in the morning and afternoon and 10-minute the VOR showed he initialed several checks. He stated the following: He has been employed at the facility since June 2015. He verified his entries on the VOR. According to Glanville, during his first check of youth [redacted], JDOS Manaigo, and he went to the youth's room and the youth told him that his chest was "stabbing him" and he could not breathe. *[Inspector's Note: The video surveillance placed this check around 10:19 a.m.]* Glanville said he advised JDOS Chisolm, who told him that the youth already had submitted a sick call. Chisolm went and checked on youth [redacted] and he told her the same thing. Glanville said Chisolm told the youth that she would put in another sick call. *[Inspector's Note: There was no need to enter a second sick call request in the system, as one had already been submitted at 10:18 a.m. (See Exhibit 32).]*

Glanville stated he continued his checks and at one point, youth [redacted] was clutching his chest, and he asked Glanville to call the nurse. He said he told Chisolm, who called the nurse (Nurse Adams). Reportedly, the nurse indicated that x-rays had been ordered. Glanville said he told youth [redacted] to be patient; that they were going to get him some help. According to Glanville, the nurse was in the IRO area three times that day, giving medicine to another youth. Glanville said he asked the nurse if he was going to see youth [redacted] and the nurse responded he would be right back, but he never saw the youth. Glanville stated that when the next shift came on duty (after 3 p.m.), he noticed that youth [redacted] had vomited. Chisolm then called a Code White. JDO II Yves Ferrier and he

(Glanville) escorted youth [redacted] to the nurse's station. Glanville added that prior to the Code White being called; he did not assess the situation as a medical emergency (that required calling 911).

JDO I Raymond Manaigo (Witness)
Date of Interview: October 5, 2015

The shift report for 7 a.m. to 3 p.m., August 31, 2015, noted that JDO Manaigo was assigned to the IRO and video surveillance confirmed his presence there. Additionally, the 10-minute VOR showed he initialed several checks. He stated the following: He verified his initials on the VOR and confirmed that the checks were completed. Manaigo stated that when he first came on shift, youth [redacted] asked him about making a phone call, but because the supervisor was busy, he (Manaigo) could not allow the phone call at that time. When he made a check in the morning, youth [redacted] told him he was having some chest pains. Manaigo said he told JDOS Chisolm, who told him that youth [redacted] had already seen the nurse, so they should let the youth rest. Afterwards, youth [redacted] ate and slept and he assisted the youth in making the phone call. At that time, youth [redacted] said he was in a little pain. He asked youth [redacted] if he was okay and he responded he was in a little pain, but not serious. Manaigo said he did not see any reason he needed to call 911 at the time. Manaigo added that he had to leave IRO and that when he returned; he saw JDO Ferrier and JDO Glanville escorting youth [redacted] from IRO.

JDO I Josue Lambert (Witness)
Date of Interview: September 22, 2015

The shift report for 7 a.m. to 3 p.m., August 31, 2015, noted that JDO Lambert was assigned to transportation; however, the video surveillance revealed he was in the IRO the morning of August 31, 2015. The 10-minute VOR showed he initialed one check. He stated the following: He worked the 7:00 a.m. to 3:00 p.m. shift on August 31, 2015, and was in the IRO, arriving around 7:40 a.m. He had been in training at the academy that day, but had returned to the facility from the academy because of weather. He said he knew that youth [redacted] was in a room, but he did not know the youth was on medical confinement.

He was aware of the requirement to conduct 10-minute checks when a youth is in a room and said he did at least one check of youth [redacted], noticing the youth was sleeping. He believed he did one or two checks of the youth. Lambert verified that the video coverage showed that he looked into youth [redacted] room at approximately 7:36 a.m. and at 7:41 a.m., initialing the 10-minute VOR the second time. *[Inspector's Note: This digital image correlates with a 7:42 a.m. entry by "JL" on the VOR.]* Lambert further stated he probably initialed the VOR for a check around 7:53 a.m., when the video showed he did something to the VOR at that time; however, he was unable to explain why the VOR did not reflect any entry with his initials, but showed a 7:51 a.m. entry by JDO Young. Lambert claimed he did not initial for Young. When he was questioned about JDO Young's initials for the

first two entries on the VOR, Lambert initially stated he believed he was the first person to initial the VOR and he was not sure how Young's initials were the first two entries. He maintained he did not fill in Young's initials at 7:28 a.m. and 7:37 a.m.

He later stated he could not recall if there were any entries already on the form when he posted the VOR outside of youth [redacted] room, after being instructed by Young to do a 10-minute check.

JDO II Ledarius Murphy (Witness)
Date of Interview: October 5, 2015

The shift report from 3 p.m. to 11 p.m., August 31, 2015, noted that JDO Murphy was assigned to off-site medical duties and had transported youth [redacted] to the hospital. His primary testimony was related to Allegation #5, however, with regards to a possible room check *(see Exhibit 26)*, Murphy stated he did not conduct any of the 10-minute checks on youth [redacted].

Licensed Mental Health Counselor Ricardo Sardina (Witness)
Date of Interview: October 13, 2015

The video surveillance showed that therapist Sardina looked into youth [redacted] room, while the youth was in medical confinement in the IRO. He stated the following: He looked into youth [redacted] room on August 31, 2015. Youth [redacted] did not say anything to him or give any indication that he was in pain. The youth's room was messy and the sheets were on the floor. Sardina verified his mental health review that was included in the Confinement Report.

Assistant Superintendent Samuel Thelon (Witness)
Date of Interview: December 21, 2015

Assistant Superintendent Thelon was interviewed relative to what is expected of supervisors regarding confinements and on applicable policies. He stated the following: He has been with DJJ since 2006 and has been an assistant superintendent since September 2015 (acting in that position for the year prior). Prior to this, he was a supervisor for approximately 2-3 years. Thelon stated that all the supervisors on a shift work as a team and all were responsible for the supervisor's review in youth [redacted] confinement report. If a check was not conducted, all the supervisors would get "hit" on that shift. According to Thelon, the process however, is not written in procedures; it was the practice on which he was trained and how supervisors have been trained since.

Thelon was asked if JDOS Wallace should have done something about the four and a half hour gap between her 6:27 a.m. review and JDOS McEady's previous 2:00 a.m. review. He responded that he did not know what the policy proscribed, but said that if it happened to him, he would have notified someone in the chain of command. Thelon stated that

Wallace also should have looked at the posted VOR when she did her review. However, he was unable to cite the governing policy requiring that Wallace look at the VOR. According to Thelon, when a JDOS conducts a supervisor review, they are to check on the youth, or at least have another supervisor check on the youth; however, this was not written in policy.

Thelon stated that as for JDOS Chisolm not checking the difference in times between the checks and only generally checking that they are conducted, that was not sufficient. Chisolm was supposed to have ensured the checks were conducted every 10 minutes and should have looked into why there was a 22-minute gap in the observation of youth [redacted] (from 1:01 p.m. to 1:23 p.m., August 31, 2015).

When asked about JDO Green's claim that she was not responsible for making 10-minute checks because she was the Intake Release Officer, Thelon said he felt Green could have made checks if she was not occupied with performing an intake or release duties.

Superintendent Steve Owens (Witness)
Date of Interview: December 21, 2015

Superintendent Owens was interviewed relative to what is expected of supervisors regarding confinements and on applicable policies. He stated the following: He has been the superintendent for 3-4 months. Prior to this, he was an assistant superintendent for approximately eight years. As to which supervisor was responsible for conducting the supervisor's review of youth [redacted] confinement report, Owens said any supervisor could complete the supervisor review of the confinement report, in order to meet the two-hour in-house window.

With respect to the four and a half hour gap between reviews (2:00 a.m. to 6:27 a.m.), Owens said he was sure Wallace would have noticed the difference, however, there was no directive that required her to report that discrepancy. He added that Wallace was expected to check the VOR during her review and if she did not find a VOR, she would have been expected to start one.

According to Owens, supervisors should have been checking on the youth when conducting their supervisor reviews, but he was not aware of any written requirement for them to check on the youth or to check the VOR. He added that when the supervisors conducted their status checks, they should have checked documentation to include the VOR. He reiterated he was not aware of any written requirement for supervisors to check the VOR during status checks. Owens further stated that while there is a requirement under the Detention Rule that 10-minute checks be conducted, there is no specific requirement for anyone to further verify that the 10-minute checks are completed. In addition, there is no requirement for assistant superintendents to further ensure that supervisors are verifying 10-minute checks.

As to JDO Green's claim that as the Intake/Release Officer, she was not responsible for conducting 10-minute checks. Owens said Green had a responsibility to conduct checks if she was not occupied with performing an intake or release. Likewise, he said JDOS Chisolm was responsible for either conducting 10-minute checks or ensuring the checks were conducted, and that she failed to follow policy when she did not conduct a check or ensure that one was conducted between 1:01 p.m. and 1:23 p.m., on August 31, 2015.

Regional Director Gladys Negron (Witness)
Date of Interview: January 6, 2015

Dr. Negron was interviewed because Miami-Dade RJDC falls within the South Detention Region. She stated the following: She concurred with Assistant Superintendent Thelon's testimony that all the supervisors listed in the shift report were responsible for ensuring that 10-minute checks were conducted appropriately. This would be part of the "supervisors' capacity" to ensure the staff are performing their duties. When asked if JDOS Bronson, who was on the 3 p.m. to 11 p.m. shift, August 30, 2015 was responsible for ensuring that checks were conducted, Negron responded that Bronson would have been responsible for ensuring the checks were completed. She was not aware of where this responsibility was dictated in a written standard, but said it would be part of professional best practice.

Dr. Negron defined best practice "as a professional ensuring that all of the items that are under your purview or your job duties are taken care of, while you are at work." She elaborated that this would include making sure staff were doing what needed to be done. Dr. Negron was asked about Miami-Dade RJDC Facility Operating Procedure 1.09, Standards of Conduct, which states that failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities constitutes negligence. She concurred that this policy covered what she was referring to as professional best practices.

Dr. Negron further stated that when JDOS Wallace completed a supervisory review of youth [redacted] confinement at 6:27 a.m. on August 31, 2015; she should have addressed the four and a half hour gap between her review and JDOS McEady's previous 2:00 a.m. review. However, she was not aware of a specific written policy Wallace violated in this instance.

Dr. Negron went on to state that if a supervisor conducted a status check of the IRO, that supervisor was responsible for ensuring all confinements were being conducted properly. She agreed that when a superintendent or assistant superintendent reviews a logbook, they should review back to when it was reviewed by the superintendent or an assistant superintendent.

Assistant Secretary for Detention Services Dixie Fosler (Witness)
Date of Interview: January 14, 2016

Assistant Secretary Fosler was interviewed relative to the Department's philosophy and standards pertaining to the responsibilities of supervisors in ensuring staff are performing their duties. She stated the following: She was not aware of any written policies addressing the supervisor's responsibility for ensuring that officers conducted 10-minute checks of youth in confinement. She concurred with the detention center's practice that the supervisor on duty was responsible for ensuring the checks were completed. She concurred that Miami-Dade RJDC FOP 1.09 provided general guidance that would require supervisors to ensure duties were being performed. She did not dispute the facility management's position that supervisors conducting status checks, were also required to verify that 10-minute checks were being conducted. *[Inspector's Note: Following this interview, Detention Services provided documentation, indicating changes to the standardized facility operating procedures, which were effective as of November 12, 2015. Exhibit 33 is an addendum to FOP 3.03, Confinement, which states, "It is the expectation of all supervisors that the three (3) hour supervisory reviews are done in person, including a conversation with the youth, unless the youth is sleeping." Exhibit 34 is an addendum to FOP 3.11, Room Checks/Supervision Levels, which states, "Any time an officer is passing by a youth's room, it is expected that the officer will conduct a room check, even if it is in-between the required room check timeframes."]*

JDOS Stephen Bronson (Subject)
Date of Interview: January 13, 2016

The shift report for August 30, 2015, from 3:00 p.m. to 11:00 p.m., identified JDOS Bronson as a supervisor on that shift. He stated the following: He concurred that he was on duty as a supervisor on August 30, 2015. He stated he never stood outside youth [redacted] confinement room that day. *[Inspector's Note: The video surveillance confirmed he was not outside youth [redacted] room.]* Bronson stated that during that shift, he did not see the Visual Observation Report for youth [redacted] confinement. He concurred that a supervisor should ensure that an officer is conducting 10-minute checks for youth in confinement. He said he had no reason on that date, to question the supervisory reviews of the confinement reports that were completed by JDOS McEady.

JDOS Gabriel Carter (Subject)
Date of Interview: January 8, 2016

The IRO logbook indicated that JDOS Carter conducted a status check of the IRO area on August 31, 2015 at 7:46 a.m. He stated the following: When conducting status checks, the supervisor is responsible to check on youth in medical confinement. He verified his entry in the IRO logbook, indicating there were two youths on bedrest and one youth on precautionary observation. After reviewing the video surveillance, he confirmed he did not go to youth [redacted] room and check on the youth. He stated that on August 31, 2015;

he misread the logbook, thinking that one of the youth on bedrest was also on precautionary observation. He said at that time, he did not know there was a youth in medical confinement, and had he known there was, he would have checked on the youth.

JDOS Shatara Chisolm (Subject)
Dates of Interviews: September 22, 2015, and January 8, 2016

The shift report from 7:00 a.m. to 3:00 p.m., August 31, 2015, noted that JDOS Chisolm was assigned to the IRO during this shift. The Confinement Report for youth [redacted] also indicated JDOS Chisolm conducted some of the supervisor reviews while youth [redacted] was in medical confinement. Chisolm stated the following: She was in IRO at the times indicated on the confinement report and she completed the supervisor reviews. She confirmed that she looked at the Visual Observation Report (VOR) to make sure it was up to date, as well as consistent.

Chisolm stated she also did one visual check, verifying her initials on the VOR at 10:55 a.m. *[Inspector's Note: A review of the video surveillance confirmed Chisolm conducted a check around 11 a.m.]* She said JDOS Grant called her at one point and she told Grant the youth was stable and resting. Grant did not ask her to see if the VOR was being conducted. Chisolm said she did not know that a VOR had not been conducted prior to 7:28 a.m.

During her subsequent interview, Chisolm stated the following: JDO Young and she were assigned to the IRO on August 31, 2015. Also present, were JDO Manaigo and JDO Glanville, who were in on-the-job training status. She did not recall conducting a check of youth [redacted] around 1:11 p.m. *[Inspector's Note: The video surveillance did not show anyone checking on youth [redacted] around that time.]* She could not remember what she was doing at the time, and assumed JDO Manaigo and JDO Glanville were conducting the checks. *[Inspector's Note: The IRO logbook indicated that at 1:15 p.m., Chisolm annotated the release of a youth. Her prior entry was at 12:50 p.m., in which she annotated that a youth was en route to court. The logbook also indicated Manaigo was out of the area, returning at 1:18 p.m.]* She reiterated she had no knowledge the check was not conducted. Chisolm initially stated that she did not instruct Manaigo or Glanville to conduct the checks, but later stated that when both officers were going to respond to a Code Blue earlier, she told them someone needed to stay and conduct checks. She admitted she did not follow up afterwards to make sure they were conducting checks.

Former JDOS Jeremy Dollard (Subject)
Date of Contact: September 18, 2015

The shift report from 3 p.m. to 11 p.m. on August 31, 2015 reflects that Dollard was a supervisor assigned to conduct unannounced Prison Rape Elimination Act (PREA), point of service, and perimeter checks. Video surveillance showed he had looked into youth

[redacted] room while youth [redacted] was in medical confinement. Dollard was terminated on September 4, 2015.

During a telephone call on September 18, 2015, Dollard agreed to be interviewed by the OIG on September 22, 2015. On September 21, 2015, Leslie Holland called Inspector Bodnar, stating she was an attorney representing Dollard and said Dollard was declining an interview. Dollard was sent a letter on September 24, 2015, to confirm his declination of an interview. As of the date of this report, Dollard has not contacted the OIG, indicating he reconsidered an interview.

JDOS Shannon Grant (Subject)
Date of Interview: September 22, 2015

The shift report from 7 a.m. to 3 p.m., August 31, 2015, noted that JDOS Grant was one of the supervisors on duty and was assigned to Module 2, Central, and the snack program. She was also responsible for completing the shift report. The Confinement Report for youth [redacted] indicated that Grant conducted at least one of the supervisor reviews while the youth was in medical confinement. She stated the following: During the shift change briefing on August 31, 2015, she became aware that youth [redacted] was on medical confinement. She verified her two entries in the Confinement Report and said supervisors are responsible for updating the confinement report every two hours. She stated she did not visit youth [redacted] in confinement that day, but obtained information about him from JDOS Chisolm (who was in the IRO), and then entered that information into the Confinement Report. According to Grant, because Chisolm was a supervisor, there would not be any reason for her (Grant) to check the VOR. In a follow-up interview, Grant admitted her responsibilities included ensuring the 10-minute checks were being conducted. She said she assumed the checks were conducted, but never checked with anyone to verify they were.

Former JDO I Utanda Green (Subject)
Date of Interview: September 22, 2015

The shift reports note that JDO Green was assigned to the IRO from 3:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015, and that she annotated youth [redacted] confinement status in the IRO logbook. Green was terminated on September 4, 2015. She stated the following: On August 30, 2015, she was assigned to the IRO. According to Green, while it was a normal practice at the facility to place youth on medical confinement in the IRO, her primary job responsibilities were those of the Intake/Release officer, and that another officer would be responsible for checking on any youth in confinement. *[Inspector's Note: JDOS Wallace disputed this assertion, stating if there were no intakes or releases to be performed; the IRO assigned staff could perform checks. Additionally, the logbook showed that Green escorted youth [redacted] to the nurse's station at 7:58 p.m. on August 30, 2015. JJIS indicated youth [redacted] had been admitted to the detention center on August 17, 2015, and was still at the center on September 29, 2015.*

This would indicate his presence in the IRO on August 30, 2015 was not related to an intake or release. Thus, Green's escort of the youth to the nurse's station indicates that she did perform functions outside of intake and release.]

Green stated that during her second shift (11 p.m. to 7 a.m.) she worked with JDO Randolph. She did not remember if Randolph conducted the 10-minute checks on youth [redacted] during their shift; however, she conducted the 30-minute checks per the March 2015 directive. She said that once the youth went into a room, the 30-minute checks would not be conducted. *[Inspector's Note: The video surveillance showed only one instance of Green checking on youth [redacted].]* Green also recalled conducting a check of youth [redacted]; however, she could not recall if a VOR was posted on his door.

During Green's testimony, several inconsistencies/discrepancies were noted. First, she stated the reason she went to youth [redacted] room was to ensure that the youth had linen in his room. She acknowledged the youth had linen; however, her explanation was not supported by the facts. *[Inspector's Note: Green checked youth [redacted] room at 3:41 a.m. on August 31, 2015, yet the video surveillance showed youth [redacted] carried what appeared to be bed linen to his room at 9:17 p.m. on August 30, 2015. Green could not explain why she waited until the early morning hours before checking to see if the youth had linen.]*

Secondly, Green's claim that Randolph conducted the status checks on youth [redacted] is inconsistent with her previous statement that she did not know if Randolph conducted the 10-minute checks. Furthermore, she testified she had conducted the 30-minute checks per the March 2015 directive. Thirdly, she initially stated she was not notified that youth [redacted] was on medical confinement until the 11 p.m. shift change. The IRO logbook, however, showed Green recorded that youth [redacted] was placed on "bed rest" at 6:15 p.m. on August 30, 2015. In addition, she testified that JDOS Stephen Bronson notified her at 6:15 p.m. on August 30, 2015, that youth [redacted] was being placed on bed rest. The video surveillance showed Bronson was in the IRO around this time. Finally, she was in the IRO office area at 9:17 p.m. on August 30, 2015, when youth [redacted] walked by the IRO lobby *(Exhibit 35)*.

Former JDOS Marquise McEady (Subject)
Date of Contact: September 17, 2015

The shift report from 11:00 p.m. August 30, 2015, to 7:00 a.m. August 31, 2015, noted that JDOS McEady was the Shift Supervisor. The Confinement Report for youth [redacted] also reflects that McEady conducted at least one of the supervisor reviews while the youth was in medical confinement. McEady was terminated on September 4, 2015.

On September 17, 2015, former JDOS McEady was contacted and after being advised of the nature of the call, stated he was not interested in being interviewed. A follow-up letter

was sent on September 24, 2015. As of the date of this report, McEady has not contacted the OIG indicating he reconsidered an interview.

Former JDO II Demetrius Randolph (Subject)
Date of Contact: September 17, 2015

The shift report from 11 p.m., August 31, 2015, to 7 a.m., August 31, 2015, noted that JDO Randolph was assigned to the IRO and the video surveillance confirmed his presence. He was terminated on September 4, 2015.

On September 17, 2015, former JDO Randolph was contacted and after being advised of the nature of the call, stated he was not interested in being interviewed. A follow-up letter was sent on September 24, 2015. As of the date of this report, Randolph has not contacted the OIG indicating he reconsidered an interview.

JDOS Duviel Rosello (Subject)
Date of Interview: January 13, 2016

The shift report for August 31, 2015, from 7:00 a.m. to 3:00 p.m., listed JDOS Rosello as a supervisor for that shift. He stated the following: He concurred that he was on duty as a supervisor on August 31, 2015. He said he did not recall if he was ever outside youth [redacted] confinement room that day; however, he had no reason to dispute the video surveillance, which showed he was not outside youth [redacted] room. If he was not outside the room, he would not have seen the Visual Observation Report for youth [redacted] confinement. Rosello stated he believed a supervisor should ensure that an officer is conducting 10-minute checks for youth in confinement and said on that date, he had no reason to question whether the supervisory reviews of the confinement reports were completed by other supervisors.

JDOS Cheryl Wallace (Subject)
Date of Interview: September 22, 2015

The shift report from 7 a.m. to 3 p.m. August 31, 2015, noted that JDOS Wallace was one of the supervisors on duty. One of her assigned duties was the IRO. The Confinement Report for youth [redacted] showed JDOS Wallace conducted one of the supervisor reviews while the youth was in medical confinement. She stated the following: When she reported to work on August 31, 2015, JDO Green briefed her that youth [redacted] was on bedrest. She advised that Green was working in the IRO. When asked about the responsibilities of staff assigned to the IRO, Wallace stated their primary responsibility is to conduct all intake and releases from the facility, and there should be an additional staff member positioned in the IRO whenever youth are in confinement, to perform the 10-minute checks. She further stated that if not conducting intakes or releases, however, the IRO assigned staff member could perform the 10-minute checks. Wallace stated she physically checked on youth [redacted] sometime after she returned from court, between 11 a.m. and 12 p.m. She

said that (after stepping out of the elevator in the IRO) she saw youth [redacted] sitting at the desk speaking on the telephone. *[Inspector's Note: This was confirmed on the video surveillance.]* Wallace said she obtained the information she entered into the Confinement Report for youth [redacted] from JDO Green. She initially stated that supervisors normally do not check the VOR, but she later admitted she is supposed to ensure staff are completing and documenting 10-minute checks on the VOR. She admitted she did not check to see if the VOR was completed and acknowledged she should have checked to ensure staff were completing the 10-minute checks prior to completing the Confinement Report. Wallace agreed that if she had noticed a VOR was not being completed properly, she would have been able to correct the matter.

Former JDOS Joshua Washington (Subject)
Date of Contact: September 22, 2015

The shift report from 3:00 p.m. to 11:00 p.m. August 30, 2015, noted that JDOS Washington was assigned to the IRO during this shift. Washington also was listed as the Shift Supervisor and the Confinement Report for youth [redacted] showed Washington conducted two supervisor reviews while the youth was in medical confinement. Washington was terminated on September 4, 2015.

Washington was called on September 17, 2015 and a message was left on the voice mail. Telephonic contact was made with Washington on September 22, 2015, and he stated he would call back. Washington did not respond by October 2, 2015 and he was mailed a letter requesting an interview. As of the date of this report, Washington has not responded.

JDO II Michael Young (Subject)
Date of Interview: September 22, 2015
[Inspector's Note: Young resigned on February 22, 2016.]

The shift report from 7:00 a.m. to 3:00 p.m. August 31, 2015, noted that JDO Young was assigned to the IRO during this shift. The video surveillance showed he was in the IRO that morning and the 10-minute VOR indicated he initialed several 10-minute checks. He stated the following: He had been at the Miami Dade RJDC for 11 years. He knew that youth [redacted] was in the IRO on medical confinement when Young was in IRO for about 45 minutes, during the morning of August 31, 2015. He remembered telling the officer who relieved him, to make sure the 10-minute checks were conducted. While in the IRO, he conducted some 10-minute checks on youth [redacted] and documented those in the VOR. He confirmed conducting the initialed checks at 7:28 a.m. and 7:37 a.m. He said he started the checks and put a new VOR on the wall. *[Inspector's Note: The video surveillance did not support this statement by Young. It revealed that JDO Lambert put the VOR on the wall outside of youth [redacted] room.]*

Based on discrepancies between his testimony, the VOR, and the video surveillance, Young was shown the video surveillance coverage of the IRO for the morning of August

31, 2015. After reviewing the video surveillance, he admitted he did not conduct the 10-minute check for 7:28 a.m., even though he initialed the VOR indicating he did so. When questioned about making certain checks for which he initialed the VOR, Young admitted that he only passed youth [redacted] room once during a period for which he had initialed that he conducted three checks. Young was unable to explain how his initials appeared on a 10-minute check around 7:51 a.m., even though he was not near youth [redacted] room at that time. Young admitted that up until 8:09 a.m., he only conducted two of the five checks he initialed on the VOR. In addition, contrary to his earlier testimony, Young admitted that Lambert put the VOR outside of youth [redacted] room. He said he did not recall if he asked JDO Lambert to put his initials on the VOR, and admitted that through his actions, he falsified some of the checks.

JDO II Yves Ferrier and **JDO I Kendra Hicks** were also interviewed during this investigation, however, their testimony was deemed not relevant to this allegation.

Conclusions/Recommendations: Based on documents reviewed and interviews, there is sufficient evidence to prove former JDO I Utanda Green, former JDO II Demetrius Randolph, former JDOS Joshua Washington, JDOS Shatara Chisolm, and former JDO II Michael Young failed to conduct 10-minute checks and failed to properly supervise youth [redacted] while he was in medical confinement. There is also sufficient evidence to prove that JDOS Gabriel Carter, JDOS Jeremy Dollard, JDOS Shannon Grant, former JDOS Marquise McEady, JDOS Cheryl Wallace, and Washington failed to ensure that the checks were conducted and ensure the proper supervision of youth [redacted]. There was no Visual Observation Report (VOR) completed by Washington, Green, and Randolph and there were sporadic and inconsistent checks during the shifts these officers were assigned. Video surveillance revealed that Young failed to conduct two of five checks he initialed. In addition, neither Chisolm nor Young conducted a later 10-minute check during the shift, resulting in a 22-minute gap in supervision. McEady, Grant, Wallace, Washington failed to note the above discrepancies by the aforementioned staff during their reviews of the confinement report and did not correct the problems. Carter admitted he did not check on youth [redacted] during a status check on August 31, 2015. Finally, Dollard escorted youth [redacted] to his room on one occasion and later checked on him, but he never raised a concern about the lack of a VOR. As a result, each of these officers were in violation of provisions of Chapter 63G-2 of the Florida Administrative Code; Chapter 60L-36.005, Disciplinary Standards, Florida Adminstrative Code; the Detention Services Manual; and various DJJ and facility policies and procedures. Therefore, the allegations of Improper Conduct and Improper Supervision against Carter, Chisolm, Dollard, Grant, Green, McEady, Randolph, Wallace, Washington, and former JDO II Young are **SUSTAINED**.

Due to the inconsistency between the VOR and the video surveillance, as well as Young's own admission that he falsified the VOR, the allegation against him is **SUSTAINED**.

As JDOS Bronson and JDOS Rosello did not respond to youth [redacted] room while he was confined in IRO and had no reason to question the reviews conducted by other supervisors, they are **EXONERATED** of Improper Conduct and Improper Supervision.

There was no specific policy requiring that supervisors ensure 10-minute checks be conducted; however, the Miami-Dade RJDC Facility Operating Procedure 1.09 provided general guidance in this area, stating that "failure to use ordinary or reasonable care or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence. Therefore, this was determined to be a **Policy Deficiency**. It is recommended that Detention Services review this matter and develop policy or update existing standards to address the responsibility of supervisors in ensuring that 10-minute checks are being conducted by officers.

Allegation #3: Medical Neglect

Synopsis – Licensed Practical Nurse (LPN) Peter Beckford and LPN Thomas Adams failed to follow the established medical procedures/protocols with regards to health care provided to youth [redacted]. *[Inspector's Note: During the week of the incident, medical staff were on site Mon-Fri from 6:00am-10:30pm, and from 7:00am-7:30pm Saturday/Sunday.]*

Applicable Statutes/Rules/Policies/Guidance

Chapter 63M-2.009, Episodic Care, Florida Administrative Code (F.A.C) – This rule provides the following applicable guidance related to urgent medical issues. Paragraph (4) states, "If a program utilizes a Licensed Practical Nurse (LPN) without the presence of a Registered Nurse on-site, then the LPN shall review all episodic or emergency cases daily (either electronically, telephonically or in person) with either the Registered Nurse or a higher licensure level health care staff." Paragraph (6), "All staff members shall have access to contact Emergency Medical Services (EMS) by calling "911" immediately under any circumstances that require immediate medical attention or evaluation." Paragraph (8) states, "The Designated Health Authority or physician designee shall be notified when a youth requires emergency transfer off-site for evaluation, treatment, and/or hospitalization."

Miami-Dade RJDC Facility Operating Procedure 7.01, Designated Health Authority (DHA)/Designee, DHA/Designee Admission Notification – Under Paragraph 2, this procedure states that the DHA has delegated routine clinical responsibilities to the Advanced Registered Nurse Practitioner (ARNP), who will have collaborative practice protocol in place, that are revised annually if needed. Paragraph 7 states that clinical decision-making with regards to the provision of health care rests with the specific medical staff providing the direct care as long as it is within the scope and standards of practice for the discipline. It further states, "Where there is any question or need for consultation or referral the medical staff will contact the DHA and final disposition will rest with the DHA." Paragraph 12 states the DHA, in conjunction with the facility superintendent is responsible for the development, review and approval of all health related procedures and protocols to be used at the facility. Paragraph 13 states that nursing staff shall review, sign, and date a cover page on which all FOPs, treatment protocols, and other procedures are listed.

Miami-Dade RJDC Facility Operating Procedure 7.05/ Sick Call-Request, Complaints, Visits and Encounters, Youth Health Care Services Orientation, Episodic/First Aid Care and Emergency Care and Off Site Care Referral – This procedure under Paragraph 7, Sick Call Referrals, states "Sick call conducted by an LPN will be reviewed on a daily basis by the RN or DHA via email, telephone or person-to-person," Paragraph 10, Sick Call Documentation – Medical Staff, states nurses and physicians will document evaluation, assessments and plans in the youth's individual healthcare record. It further states, "The documentation of all assessments and interventions may be made onto the hard copy Sick Call Request Form and filed with the Progress notes." *[Inspector's Note: Chapter 63M-2.0035 (Health Services) Protocols and Procedures, Florida Administrative Code, under Paragraph (5), states that documentation of implemented treatment protocol shall be recorded by one of four different methods, to include the Sick Call Request Form. This appears to indicate documentation in a Chronological Progress Note would not be required in this case.]*

The following medical treatment protocols, among those in place at the Miami-Dade RJDC at the time of the subject incident (*Exhibit 36*), were deemed applicable:

Protocol for Chest Pain (MSS-DJJS-CL-018) – This protocol for chest pain indicates the pain "must be clinically assessed to differentiate a true cardiac condition or event from possible other conditions." Subjective questions include addressing the onset, location, duration, and other precipitating factors of the injury; rating of pain on a 1-10 scale; changes in pain relative to breathing and position changes; history of chest trauma; respiratory issues; fainting, dizziness, and seizures, pain associated with meals; and family and patient history. This protocol requires calling 911 if the assessment indicated cardiac involvement. It also requires consultation with a healthcare provider if there are abnormal findings; indications of other conditions; persistent pain; or treatment interventions are ineffective and the symptoms continue.

Protocol for Head Injuries (MSS-DJJS-CL-030) – This protocol for head injuries includes subjective questions addressing when, where, and how the injury occurred; previous history; rating of pain on a 1-10 scale; vision changes, headache, nausea or vomiting, dizziness, and trouble with walking and talking; and confusion. If the patient is conscious and stable, there should be continued neurovascular assessments and vital signs every two hours, done twice, then every four hours for 24 hours. The protocol instructs the medical doctor is to be notified of all head injuries. The patient is to be placed in the medical observation area until rescinded by a doctor's order.

Record Reviews - During the course of the investigation, unless otherwise noted, the investigative team the following records:

Post-PAR Medical Review (*Exhibit 37*) – This review by Nurse Beckford indicated youth [redacted] was seen at 5:45 p.m. on August 30, 2015, following an altercation with other youth. While the youth stated he had no complaints, he had swelling over his left eye, but no loss of vision or visual disturbance. Youth [redacted] was given ice to apply to his face

and placed on concussions precautions for 24 hours. *[Inspector's Note: There are additional entries on this form; however, to present the documentation in chronological order, they will be addressed later in this section.]*

Youth Alert Notes Report for youth [redacted] (*Exhibit 23*) – This report showed Nurse Beckford created an alert at 6:12 p.m., August 30, 2015, indicating youth [redacted] was placed on Concussions Precautions for 24 hours and noted the youth should be monitored for "repeated vomiting, dizziness, headache, visual disturbances, seizures, confusion, or unusual drowsiness." The report also noted the youth "should also be awoken if he is sleeping every 2 hours to assess youth's alertness."

Confinement Report for Youth [redacted] (*Exhibit 22*) – This report noted youth [redacted] was placed on medical confinement on August 30, 2015, at 6:15 p.m., Youth [redacted] was placed on medical confinement for "24 hours concussion precaution" per Nurse Beckford, and noted he had been involved in a physical altercation.

Post-PAR Medical Review (*Exhibit 37*) – Nurse Beckford posted a follow-up entry at 8:45 p.m., in which he reported that youth [redacted] complained of body aches and had notable "rub burns" on his shoulders. The youth was administered 400 mg of Ibuprofen and told to notify medical if his condition does not improve or worsens.

Sick Call Request for youth [redacted], dated August 31, 2015, 10:18 a.m. (*Exhibit 32*) – This was a request for medical care and noted the youth complained of body sores. Nurse Adams recorded the following: Youth [redacted] denied nausea, dizziness, or any visual disturbance. He had been seen the day prior after being involved in a Code Blue altercation. Youth [redacted] stated he had been attacked by several youth. The youth "was given PRN pain medication as established by his active PCP." *[Inspector's Note: PCP stands for Patient Care Protocol.]* An X-ray was to be ordered. Nurse Manager Carol Marquez, Registered Nurse (RN), reviewed this request on September 1, 2015, and marked it Resolved with no interventions needed at the time, as the "youth was treated according to the PCP."

Code White Progress Note (*Exhibit 38*) – This note contained a single entry made at 3:40 p.m. on August 31, 2015, by Nurse Adams, documenting that youth [redacted] was brought to medical with complaints of stabbing pain in the middle to right side of his chest. The youth stated the pain felt like something was stuck in his chest. The youth said he has felt this way since being involved in an altercation on August 30, 2015, when he was "stomped in his chest several times by youth." The youth denied difficulty in breathing, but was clutching the right side of his chest and vomiting. The youth reportedly demanded to be sent to the hospital. The note concluded stating that the youth would be sent to the hospital.

Emergency Referral for youth [redacted] (*Exhibit 39*) – This record noted that youth [redacted] was referred to Holtz Children's Hospital on August 31, 2015, at 3:40 p.m., for

"stabbing pain in chest after physical altercation on 8/30/15." The referral is signed by Nurse Adams.

Post-PAR Medical Review (*Exhibit 37*) – There are two other entries to this form, one at 4:20 p.m. on August 31, 2015, and the other at 10:50 a.m., on September 1, 2015, both appear to have been made by Nurse Adams. The 4:20 p.m. entry appears to indicate youth [redacted] was sent to the hospital due to continued complaining of stabbing pain in his chest, since a physical altercation on August 30, 2015. The entry indicated the youth was vomiting and unstable. The DHA (Designated Health Authority) was notified. *[Inspector's Note: This is the first documentation found indicating the DHA was notified.]*

The entry on September 1, 2015, indicated that at 8:40 a.m. on August 31, 2015, youth [redacted] was brought to medical, complaining of body ache due to trauma on August 30, 2015. Reportedly, the youth did not feel well and complained of soreness throughout his body. The youth stated he felt something was stuck in his throat. Nurse Adams wrote the youth was in no acute distress and he denied any nausea, dizziness, or any visual disturbance. Adams wrote that the youth has an active PCP and he was sent back to medical confinement. *[Inspector's Note: Late entries are common if the medical staff is unable to immediately document their actions.]*

Nurse Logbook (*Exhibit 40*) – This record noted the following information regarding youth [redacted]:

- At 5:50 p.m., on August 30, 2015, JDOS Bronson arrived in medical with youth [redacted] who had been involved in a physical altercation on Module 9.

- At 3:41 p.m., on August 31, 2015, JDO Ferrier and JDO Glanville were in the Nurse Station with youth [redacted].

Nursing Shift to Shift Report (*Exhibit 41*) – This record noted that on August 30, 2015, Nurse Beckford documented for Nurse Adams' information, that youth [redacted] was placed on 24 hours concussion precautions following a Code Blue.

List of youth to be seen by the doctor (*Exhibit 42*) – This document, which was obtained from the nurse's station, noted that youth [redacted] was scheduled on August 28, 2015, to be seen by the medical doctor at some time in the future.

Interviews - Unless otherwise noted, the investigative team conducted the following interviews, which were sworn and electronically recorded.

Nursing Manager Carol Marquez, RN (Witness)
Date of Interview: September 22, 2015

Marquez was interviewed as she is the Nurse Manager at the Miami-Dade RJDC and she reviewed youth [redacted] Sick Call Request. She has been at the facility for a year and a half. She stated the following: She is a Registered Nurse and oversees the clinic, making all the youth appointments for outside medical care. She did not work on August 30, 2015, however, she responded to the facility the morning of August 31, 2015.

Marquez advised that in regards to Sick Call Requests, she reviews the requests within 24 hours of receipt, weekends excluded. She stated that when she reviewed youth [redacted] request on September 1, 2015, no intervention was needed as the youth had already passed away. Even though this sick call request was for body sores, she was aware of youth [redacted] being treated under the head injury Patient Care Protocol (PCP), when she came to work around 8:00 a.m. on August 31, 2015. She said she learned this information from the Shift to Shift report. When asked if the PCP was being followed properly, she stated the staff knew what they needed to do and she never had any concern to question the staff. She added that if the youth had needed further assessment; staff would have come to her.

Marquez stated she did not review youth [redacted] chart that day because she had other duties, but she reviewed the chart on September 1, 2015. When she reviewed the chart, she became aware that the vitals were not checked initially for three hours. When asked if there was a requirement that she review the medical file to evaluate the nurses' treatment of youth, Marquez responded that her only requirement was to review sick call requests within 24 hours. There was no requirement for her to check youth [redacted] chart by any other specific time.

Nurse Peter Beckford, LPN (Subject)
Date of Interview: October 5, 2015

Beckford was identified in documentation as responding to youth [redacted] in the nurse's station the evening of August 30, 2015. He has been at the facility since 2010. After referring to his Post-PAR Medical Review *(Exhibit 37)*, which he verified as his entry, he stated the following: He first saw youth [redacted] at 5:45 p.m. on August 30, 2015. The youth had no complaints; however, Beckford noted there was swelling over the youth's left eye. Youth [redacted] stated the injury to his eye was sustained during a fight. There was no discussion regarding how many youth were involved in the fight, the extent of the strikes against him, or where he was hit. Beckford stated that the staff did not disclose this information to him and he had not reviewed the video surveillance of the altercation.

Beckford advised that he placed youth [redacted] on concussion precautions. When asked why the youth was placed on concussion precautions, which did not appear to be a nursing protocol, Beckford stated he did so because the youth might have had a head injury, even

though the youth had no signs or symptoms. He added that some people might have a head injury with no signs or symptoms; but hours later, they have a complaint of a head injury. When asked if he followed the head injury protocol, Beckford said he did not use the head injury protocol.

Beckford initially stated he notified the doctor at around 8:45 p.m. on August 30, 2015, of youth [redacted] status, by placing the youth's name on the list of youth to be seen by the doctor. After being shown the doctor's list (*Exhibit 42*), Beckford clarified his statement, saying that youth [redacted] was placed on this list upon his admission to the detention center on August 28, 2015. *[Inspector's Note: It is a standard practice to schedule youth for a session with the doctor when the youth is first admitted to the facility.]* Beckford advised he did not place youth [redacted] on the list again on August 30, 2015, because the youth was already on the list. He further stated the protocol does not dictate when he has to notify the doctor.

Beckford continued to state that he conducted a second assessment and vital signs check of youth [redacted] three hours after the first check, because he was attending to other youth and changing the dressing of a youth with a gunshot wound. *[Inspector's Note: The protocol requires continued neurovascular assessments and vital signs every two hours, conducted twice, then every four hours for 24 hours.]* When asked in a direct follow-up question, if he followed the head injury protocol when he placed youth [redacted] on concussions precautions, Beckford responded "Yes." Beckford reiterated that he did not conduct the second assessment within two hours as directed in the protocol, because he was attending to other youth. He said he used the Youth Alert Note to arrange for staff to check the youth every two hours for vomiting, dizziness, headaches, and similar issues; however, the alert did not indicate that staff were to check for vital signs.

Beckford maintained that youth [redacted] never complained to him about chest pains.

Nurse Thomas Adams, LPN (Subject)
Date of Interview: September 22, 2015

Adams was interviewed because he attended to youth [redacted] the morning and afternoon of August 31, 2015, in response to youth [redacted] complaints of pain. Adams had been employed at the facility since 2009. He stated the following: He did not have any contact with youth [redacted] on August 30, 2015; however, he saw the youth on August 31, 2015, because the youth had complained of not feeling well. He said he was told the youth had been involved in an altercation the day before; however, neither youth [redacted] or staff described the altercation, the number of youth involved, or the type and extent of strikes sustained by youth [redacted]. He stated he did not see the incident on the video surveillance coverage.

Adams verified that he completed the Sick Call Request Form for youth [redacted] *(Exhibit 32)*. He said he knew the youth was placed on concussion precautions, which are a

precautionary step taken if it is suspected that a youth has a head injury and he knew the active PCP for youth [redacted] was the head injury protocol *(Exhibit 36)*.

Adams also verified the Code White Progress Note as the documentation regarding the afternoon visit by youth [redacted] *(Exhibit 38)*. According to Adams, during the afternoon visit, the youth said he was hit/stomped in the chest, but had not revealed that information previously. The DHA was only notified when youth [redacted] was sent to the hospital. When asked why the DHA was not notified earlier, Adams said there was no reason to notify the DHA after youth [redacted] morning visit. When asked about the provisions of the head injury protocol, which state there are to be continuous assessments of the youth and the medical doctor is to be notified of all head injuries, Adams advised he did not establish the protocol for youth [redacted], and did not see any reason to notify the doctor after seeing youth [redacted] the morning of August 31, 2015.

Adams admitted that he did not follow the protocol properly and that was why he was no longer working at the Miami-Dade RJDC. He admitted he did not check youth [redacted] vitals as prescribed in the protocols, which required continued neurovascular assessments and vital signs every two hours, conducted twice; then every four hours, for 24 hours. *[Inspector's Note: The medical documentation indicates Adams checked the youth's vital signs at 9:00 a.m. and 3:40 p.m. on August 31, 2015.]*

Conclusions/Recommendations – Based on documents reviewed and interviews, there is sufficient evidence to prove Nurse Peter Beckford and Nurse Thomas Adams failed to follow the head injury protocol for the treatment of youth [redacted]. Beckford had placed the youth on concussion precautions and Adams was aware of that placement and both nurses testified that this would indicate a suspected head injury. The head injury protocol provides for continuous assessments and notifications of the medical doctor. Both nurses testified these actions were not taken. After consulting with the contracted health care provider, Correct Care Solutions, it was determined that Beckford's actions did not constitute proper notification of the doctor, as required *(See Exhibit 43)*. Since Beckford did not notify the doctor as required and Adams did not check youth [redacted] vitals per protocol, the allegation of Medical Neglect against both individuals is **SUSTAINED**.

It is recommended that DJJ/OHS review the issue and forward this information to the Florida Board of Nursing, to determine whether Beckford and Adams complied with the Nurse Practice Act. Please see Section V, Additional Matters.

Allegation #4: Improper Conduct

Synopsis – JDOS Duviel Rosello and JDOS Joshua Washington acted improperly by not immediately transporting youth [redacted] to the hospital, after Nurse Adams had directed he be taken to the hospital.

Applicable Statutes/Rules/Policies/Guidance

Chapter 63G-2.024, Safety, Florida Administrative Code (FAC) – This rule states under paragraph (7), "In the event emergency medical services are required, staff shall call 9-1-1." It further states under subparagraph (a) "Any detention facility staff, contracted employee, teacher or volunteer has the right and responsibility to contact 9-1-1 (emergency services) if it is felt that a potentially life-threatening situation exists."

Miami-Dade RJDC Facility Operating Procedure 1.09, Standards of Conduct – This procedure under Paragraph E of Procedures, states that staff will always provide for the youth's basic needs and "will not, through inaction or inattention, allow these needs to remain unmet." Furthermore, under Paragraph H, DMS Standards of Conduct, this procedure states that "failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence. This paragraph also states falsification of records, documents, reports, logs, or statements constitutes a violation of standards.

The OIG found no specific policy mandating a specific time-frame in which a youth must be transported, after being referred to outside medical care.

Record Reviews - During the course of the investigation, unless otherwise noted, the investigative team reviewed the following records:

Miami-Dade RJDC Shift Report for August 31, 2015, from 3:00 p.m. to 11:00 p.m. (*Exhibit 21*) – As previously indicated, this report noted that JDO Murphy and JDO Hicks transported youth [redacted] to Jackson Memorial Hospital Holtz emergency room, due to vomiting and nausea. JDOS Washington was listed as the Shift Supervisor.

Code White Progress Note (*Exhibit 38*) – This note indicates Nurse Adams documented that at 3:40 p.m. on August 31, 2015, youth [redacted] was brought to medical with complaints of stabbing pain in the middle to right side of his chest. The youth stated the pain felt like something was stuck in his chest and said he has felt this way since being involved in an altercation on August 30, 2015, when he was "stomped in his chest several times by youth." The youth denied difficulty in breathing, but was clutching the right side of his chest and vomiting. The youth reportedly demanded to be taken to the hospital and the note concluded, stating he would be sent to the hospital.

Emergency Referral for youth [redacted] (*Exhibit 39*) – This document noted that Nurse Adams referred youth [redacted] to Holtz Children's Hospital on August 31, 2015 at 3:40 p.m., for "stabbing pain in chest after physical altercation on 8/30/15."

Post-PAR Medical Review (*Exhibit 37*) – A 4:20 p.m. entry on August 31, 2015, noted that youth [redacted] was being sent to the hospital, due to continued complaining of stabbing pain in his chest since a physical altercation on August 30, 2015.

Excerpt from Master Control Log (*Exhibit 44*) – The Master Control Logbook documented that youth [redacted] was transported to the hospital around 4:56 p.m. on August 31, 2015.

Video Surveillance of Nurse's Station – Afternoon of August 31, 2015, and selected digital images (*Exhibits 45 and 46, respectively*) – Video surveillance of the nurse's station, to include the lobby area from 3:44 p.m. to 4:47 p.m., identified those present throughout the time youth [redacted] was there. Key events are identified as follows:

- 3:44 p.m. – JDOS Ferrier and Glanville escorted youth [redacted] into nurse's station. Also present, were Nurse Adams, Nurse Manager Marquez, JDOS Washington, JDOS Grant, and JDOS Rosello.
- 3:53 p.m. – Youth [redacted] placed his hand on his chest.
- 3:54 p.m. – Nurse Adams handed Rosello a piece of paper.
- 3:59 p.m. – Youth [redacted] appeared agitated and in pain. Medical Records Clerk Lashawn Lewis-Jenkins was observed in the area.
- 4:07 p.m. – Rosello made several phone calls.
- 4:11 p.m. – Youth [redacted] had his face inside a biohazard bag, possibly vomiting.
- 4:15 p.m. – JDO Hicks arrived and left shortly afterwards.
- 4:20 p.m. – Youth [redacted] and JDO Glanville move to the lobby area.
- 4:22 p.m. – Hicks returned to the nurse's station and twice looked out into the hall at 4:32 p.m. and 4:43 p.m.
- 4:45 p.m. – Superintendent Owens arrived at the nurse's station.
- 4:47 p.m. – JDOS Hicks and Glanville escorted youth [redacted] from the nurse's station.

Hospital Documentation (*Exhibit 47*) – Documentation from Jackson Memorial Hospital reflects that youth [redacted] was admitted to the emergency room at 5:17 p.m. on August 31, 2015. It was noted that youth [redacted] had been assaulted on August 30, 2015, by "18 other inmates, with resultant chest pain following incident, and emesis today." *[Inspector's Note: Emesis is the action or process of vomiting.]*

Authorization to Consent for Treatment (*Exhibit 48*) – This form indicates that on August 31, 2015, JDOS Rosello signed as the Administrator of facility or DJJ Representative, and that he designated JDO K. Hicks as his representative, authorized to sign for youth [redacted] treatment at Jackson Memorial Hospital. The form also included Hicks' signature.

Interviews - Unless otherwise noted, the investigative team conducted the following interviews, which were sworn and electronically recorded.

JDO I Author Glanville (Witness)
Date of Interview: October 5, 2015

Documents and video surveillance showed that JDO Glanville was in the Intake/Release Office (IRO) on August 31, 2015, and he escorted youth [redacted] to the nurse's station. He stated the following: Once in the nurse's station, youth [redacted] vomited repeatedly and tried to catch his breath. Youth [redacted] told Nurse Adams he needed to call the hospital and Nurse Adams told the youth he was filling out the paperwork to send him to the hospital.

According to Glanville, JDO Hicks came into the nurse's station and in response to his (Glanville's) question, stated that youth [redacted] would be transported to the hospital in a state vehicle. Hicks told him they were waiting for JDO Murphy to get relieved. Hicks kept looking out the door, asking the supervisors where the transport was. Youth [redacted] then went to the waiting area to lay down and he (Glanville) went and sat with him. Youth [redacted] was talking and joking with Hicks and him. Nurse Adams came and said he thought youth [redacted] was in pain. Youth [redacted] said he was doing what he could to take his mind off the pain and described it as a 20, on a scale of 1-10.

Glanville further stated that while in the waiting area, youth [redacted] told him that a group of youth had jumped him and that the youth had asked the nurse since Sunday (August 30, 2015) to send him to the hospital. *[Inspector's Note: Inspector Bodnar spoke with Glanville on October 22, 2015, to confirm what youth [redacted] reportedly told him about asking the nurse to go to the hospital on Sunday. Glanville confirmed the youth's statement, but provided no further information, other than to say he believed JDO Ferrier also might have heard youth [redacted] make this statement.]*

Glanville added that at the time, youth [redacted] actions did not warrant him calling 911. He believed a supervisor made the decision to transport youth [redacted] to the hospital, but he was not sure which supervisor. Glanville said he left the facility at 6:30 p.m. and he saw staff putting shackles on youth [redacted] to transport him. *[Inspector's Note: This information is inconsistent with the Master Control Logbook (Exhibit 44), which showed the youth was transported to the hospital at 4:56 p.m. The 4:56 p.m. transport time was confirmed by video surveillance and staff testimony.]*

JDO II Yves Ferrier (Witness)
Date of Interview: October 5 and 22, 2015

Video surveillance showed that JDO Ferrier escorted youth [redacted] from the IRO to the nurse's station the afternoon of August 31, 2015. He stated the following: When he reported for duty in the IRO, JDOS Chisolm told him a youth needed to go the nurse's station. JDO Glanville was standing by the door and youth [redacted] was in the room sitting down. Youth [redacted] said he had been vomiting throughout the day. *[Inspector's Note: There is no other indication the youth had been vomiting throughout the day. The August*

31, 2015 sick call request for him noted he denied any nausea.] He and Glanville then escorted youth [redacted] to the nurse's station.

Ferrier stated that youth [redacted] told Nurse Adams he was having sensations on his right side, upper chest area. *[Inspector's Note: Ferrier said the youth used the terms "crackle" and "crackling."]* Youth [redacted] told Nurse Adams multiple times he needed to go the hospital. Ferrier said he told the youth to calm down and to breathe. Nurse Adams then took the youth's blood pressure and said he was going to send him to the hospital. Ferrier estimated the time from the youth requesting to go to the hospital to Nurse Adams making that decision at 10-15 minutes.

After reviewing the video surveillance during this interview, Ferrier stated that Nurse Manager Marquez brought youth [redacted] a biohazard bag when the youth started vomiting. She did not ask youth [redacted] any questions. *[Inspector's Note: According to Ferrier's recollection after watching the video, by 3:47 p.m., youth [redacted] already had said he needed to go to the hospital.]*

Ferrier further stated he was not aware of any discussion about how the youth should be transported to the hospital. He recalled that some 20 years ago, he was an Emergency Medical Technician and that in his opinion, it was not okay to wait an hour before transporting youth [redacted] to the hospital. He felt Nurse Adams should have responded to youth [redacted] immediately and said had the youth indicated he was having pain more to the center of his chest, he (Ferrier) would have called 911.

On October 22, 2015, Inspector Bodnar again spoke with JDO Ferrier, who stated in response to a direct question, that he did not hear youth [redacted] say he had asked the nurse on Sunday, August 30, 2015, to go to the hospital.

JDO Kendra Hicks (Witness)
Date of Interview: October 13, 2015

JDO Hicks was identified in documents, video surveillance, and through other testimony as being involved in the transportation of youth [redacted] to the hospital. She stated the following: She verified she entered the nurse's station around 4:15 p.m., August 31, 2015, and left shortly afterwards. She said she had been working in Module 2 and JDOS Washington called her to let her know she would be transporting a youth to the hospital. Before she arrived at the nurse's station, she did not know who she was going to transport. When she returned to the station after making arrangements for the transport, she learned she would be transporting youth [redacted]. He was sitting on the white slab in the lobby area holding a biohazard bag.

Hicks stated she was not aware of the details of youth [redacted] health status. She did not know why, nor did she ask why the youth was being transported to the hospital via a state vehicle. Youth [redacted] seemed agitated and told her he had vomited. She did not see any

indication of a medical emergency at the time, requiring the calling of 911. She then contacted Master Control to inquire about the transport and was told they were waiting for relief for JDO Murphy.

Hicks said she did not speak to Nurse Adams about youth [redacted] and did not recall Superintendent Owens entering the nurse's station. She added that normally, when she transports a youth to the hospital, she is in and out of the nurse's station with the necessary paperwork within 10-15 minutes. *[Inspector's Note: The video surveillance showed the time between her arrival and ultimate departure from the nurse's station for this incident was approximately 32 minutes.]*

JDO II Ledarius Murphy (Witness)
Date of Interview: October 5, 2015

JDO Murphy was identified through documents, video surveillance, and other testimony as transporting youth [redacted] to the hospital. He stated the following: JDOS Washington called him and told him he would be transporting a youth to a hospital. When he arrived at Transportation, he learned it was youth [redacted], who was already shackled. He and the youth left the building around 4:56.pm. *[Inspector's Note: Youth [redacted] departure time was verified by the video surveillance.]* No one briefed him on the status of the youth and the youth said nothing to him. Murphy advised that JDO Hicks was also on the transport. After getting in the van, they drove around the detention center and conducted an outer perimeter check, then they drove directly to the hospital.

JDOS Shannon Grant (Witness)
Date of Interview: October 13, 2015

The video surveillance showed that Grant was in the nurse's station for about two minutes, beginning at 3:44 p.m., August 31, 2015. She stated the following: During her time in the nurse's station, youth [redacted] did not say anything to her regarding his health or any pain. The youth was breathing hard and JDO Ferrier said it was hard for the youth to breath and that he was going to vomit. Grant advised she did not see youth [redacted] vomit or grab his chest.

JDOS Stephen Bronson (Witness)
Date of Interview: October 13, 2015

The video surveillance showed Bronson briefly looking into the nurse's station around 3:50 p.m., August 21, 2015. Bronson said he looked into the nurse's station as shown on the video surveillance, however, he could not recall why he looked inside, but that it was not related to youth [redacted].

Assistant Superintendent Ell Fance (Witness)
Date of Interview: October 14, 2015

Assistant Superintendent Fance was not at the facility from the time youth [redacted] was assaulted, until after the youth was transported to the hospital; however, he was interviewed for his assessment regarding the off-site medical transport of youth. Fance advised that given only the fact that a youth had complained of a stabbing chest pain at 3:40 p.m. on a Monday afternoon, he would have called 911.

Superintendent Steve Owens (Witness)
Date of Interview: October 14 and December 21, 2015

Superintendent Owens was interviewed for his assessment, having been at the facility since 2004, and serving for approximately seven years as an assistant superintendent. Additionally, the video surveillance showed he visited the nurse's station while youth [redacted] was there. He stated the following: He felt it took an exorbitant amount of time to transport youth [redacted] to the hospital. He did not think that waiting for JDO Murphy to be relieved was an acceptable reason to delay the transport. *[Inspector's Note: Owens' actions in following up on the youth being transported to the hospital in a timely manner is addressed in Allegation #5.]* In a follow-up interview, Owens stated that the supervisor makes a determination about transportation based on the assessment by medical staff. The process of how the youth was to be transported to the hospital then falls on the DJJ supervisors. Owens was not aware of any policy or procedure that prescribed the expected time to transport youth [redacted] to the hospital.

Nurse Manager Carol Marquez (Witness)
Date of Interview: December 22, 2015

Nurse Marquez was present in the nurse's station when youth [redacted] was there. She stated the following: She has been at the facility for a year and a half. Regarding the transport of youth [redacted] to the hospital, she said she and Nurse Adams discussed this matter with the DJJ staff present. Based on the youth's stable condition, it was decided to transport the youth by DJJ van. Once the decision was made as to how the youth was to be transported, the nursing staff provided the appropriate documentation to either JDOS Bronson or JDOS Rosello. Marquez said she did not know if there were any discussions with JDOS Washington, and added that there was no policy that mandated transport within a certain period of time. She further stated there was no discussion as to the length of time it took to transport youth [redacted].

Nurse Thomas Adams, LPN (Witness)
Date of Interview: January 11, 2016

Adams stated the following: He was aware of the youth complaining of chest discomfort as a result of an altercation, however, he was not aware of any details about the incident.

Once he referred youth [redacted] for outside medical care/attention, he had no further role in the process of transporting the youth from the detention center. Adams stated the youth had initial discomfort when he arrived at the nurse's station but he calmed down. He added that he observed nothing that caused him any concern during the time the youth was in the nurse's station.

Regional Director Gladys Negron (Witness)
Date of Interview: January 6, 2015

Dr. Negron stated she was not aware of any specific policy mandating a specific time-frame in which a youth must be transported to the hospital, but believed the best practice is to transport them as soon as possible.

Assistant Secretary for Detention Services Dixie Fosler (Witness)
Date of Interview: January 14, 2016

Assistant Secretary Fosler was interviewed regarding the Department's philosophy and standards for transporting youth to outside medical care/attention. She stated she was not aware of any written standards, addressing a specific time in which a youth was required to be transported, if referred for outside medical attention/care. She concurred that this matter should be reviewed by the Office of Health Services (OHS) and Detention Services.

JDOS Duviel Rosello (Subject)
Date of Interview: October 13, 2015

Video surveillance showed that JDOS Rosello was in the nurse's station several times when youth [redacted] was awaiting transport to the hospital. It appeared Rosello engaged in several conversations with JDO Ferrier, JDO Glanville, and/or youth [redacted]. He stated the following: He verified that he entered the nurse's station behind JDO Ferrier, JDO Glanville, and youth [redacted] around 3:44 p.m., August 31, 2015. He said when he returned to the nurse's station later, Adams gave him a piece of paper related to the hospital referral for youth [redacted], which he signed *(Exhibit 48)*. He then left the nurse's station for about nine minutes but could not recall what he did during that time.

Rosello stated he returned to the nurse's station and called JDOS Washington three times regarding the transport of youth [redacted], telling him that youth [redacted] needed to be transported "now." On the last call, Washington said they had things taken care of and hung up the phone. He did not know who made the decision to send the youth to the hospital via a state vehicle.

Rosello further stated that when Hicks entered the nurse's station; he knew she was one of the transportation officers because Washington had mentioned her earlier. He did not know when the youth left the facility to go to the hospital, but after speaking to Washington and with Hicks arriving, he felt there were capable officers who would take it from there.

He did not do any more follow up on the transport. He said he asked youth [redacted] at one point how he was feeling, but did not recall how the youth responded. When Hicks arrived, he felt the situation with youth [redacted] was not that grave and did not warrant calling 911. Rosello added that knowing what eventually happened to youth [redacted], he said the amount of time it took to transport him was excessive.

Rosello stated he felt he did everything he was supposed to do as a supervisor. He felt he ensured the needs of the youth were being met per the facility's policies. *[Inspector's Note: The investigative team noted that the shift reports indicated Rosello was on the 7 a.m. to 3 p.m. shift for August 31, 2015, but not the 3 p.m. to 11 p.m. for that day. Other facility documentation showed he left the facility at 4:13 p.m. that day. This documentation supported his testimony that his shift was over when he became involved with inquiring about youth [redacted] transport.]*

Former JDOS Joshua Washington (Subject)
Date of Contact: September 22, 2015

As previously stated, telephonic contact was made with Washington and a letter sent to him on October 2, 2015, requesting an interview. However, as of the date of this report, he has not responded.

Conclusions/Recommendations - Based on documents reviewed and interviews, there is insufficient evidence to prove or disprove that DJJ direct care staff acted improperly in the transportation of youth [redacted] to the hospital. Adams stated that youth [redacted] experienced initial discomfort when he arrived at the nurse's station, but that he had calmed down. Adams said he observed nothing about the amount of time the youth remained in the nurse's station that caused him any concern. Additionally, there was no specific policy addressing a specific time frame in which the youth was to be transported from the detention center, once referred for outside medical care. Therefore, this is determined to be a **POLICY DEFICIENCY** and JDOS Rosello and former JDOS Washington are **EXONERATED** of Improper Conduct with respect to this allegation.

It is recommended that DJJ/OHS review the matter and if deemed appropriate, refer this matter to Florida Board of Nursing to determine whether Adams complied with the Nurse Practice Act, relative to the transport of youth [redacted] to the hospital. It is also recommended that Detention Services establish policy addressing the appropriate and timely transportation of youth, once they are referred for outside medical care.

Allegation #5: Improper Conduct

Synopsis – Superintendent Steve Owens, Assistant Superintendent Ell Fance, Assistant Superintendent Samuel Thelon, and JDOS Stephen Bronson failed to take appropriate action after becoming aware of an incident involving youth [redacted] and his subsequent medical confinement.

Applicable Statutes/Rules/Policies/Guidance

Chapter 63G-2.015, Facility Management, Florida Administrative Code (F.A.C.) – This rule states under Paragraph (1), Accountability, that "The Superintendent or designee is responsible for ensuring compliance with all applicable laws, rules, regulations, policies and procedures related to the operation of a secure detention facility and to the proper care, custody, and control of detained youths." *[Inspector's Note: Chapter 63G-2.014, Definitions, F.A.C., under subparagraph (4), defines the assistant superintendent as the person second in command responsible for the operation of a designated juvenile detention center. By this definition, it can be reasonably concluded the term "designee" automatically includes assistant superintendents.]*

Chapter 63G-2.018, Documentation/Management Systems, Florida Administrative Code (F.A.C.) – This rule provides for the management of documents, to include confinement reports. Paragraph (1) states that all documents, including information entered into Juvenile Justice Information System (JJIS) and/or Facility Management System (FMS) represent official records. Failure to document required information, falsification of information, or failure to properly retain written documents may result in disciplinary action up to and including dismissal. Paragraph (2) provides that the Superintendent is responsible for ensuring all appropriate information is entered into JJIS and or FMS. Paragraph (3) Logbooks, subparagraph (d) states, "The Superintendent or designee shall review all logbooks at least weekly."

Chapter 63G-2.019, Security, Florida Administrative Code (F.A.C.) – This rule addresses security requirements for detention center operations. Paragraph (8), Alerts, states that in order to ensure the safety and well-being of youth, Superintendents shall be responsible for ensuring that JJIS Alerts are reviewed, responded to appropriately, and documented. *[Inspector's Note: As this rule uses the general term "Superintendents," instead of the more definitive term "the Superintendent," it can be reasonably concluded this rule applies as well to assistant superintendents.]*

Chapter 63G-2.022, Behavior Management and Disciplinary Treatment, Florida Administrative Code (F.A.C.) – This rule provides for the use of an established behavior management system promotes safety, respect, fairness, and protection of rights within the facility. Paragraph (4), Confinement, states the use of confinement shall be monitored by the Superintendent or designee, and it requires that a Juvenile Detention Officer supervisor evaluate and document the youth's status, at a minimum, every three hours to determine if the continued confinement of the youth is required. *[Inspector's Note: A review of the confinement report for youth [redacted] showed he was placed on medical confinement for "24 hours concussion precaution." In Section IV, Additional Matters – Other Investigative Activities, of the Report of Investigation for IG 15-0021, related to the death of a youth at the Brevard RJDC, it was noted that there was a need for Detention Services to address procedures for conducting ten-minute checks of youth in medical confinement, confinement for medical isolation, and medical bed rest (terms that were used interchangeably, apparently causing some confusion). Also, it was noted that the requirement to observe "skin" during the check did not appear to be sufficient in medical confinement cases, depending on the health status of the youth . . ."]*

Florida Department of Juvenile Justice Policy #1100, Rights of Youth in DJJ Care, Custody, or Supervision - This policy states, "Employed or contracted staff will treat youths with the courtesy and dignity inherently due every person. Staff will act, speak, and conduct themselves in a professional manner, recognizing their obligation to maintain public safety, and maintain a courteous, professional attitude in all contact with the public. . . ."

Miami-Dade RJDC Facility Operating Procedure 1.09, Standards of Conduct – This procedure under Paragraph E of Procedures, states that staff will always provide for the youth's basic needs and "will not, through inaction or inattention, allow these needs to remain unmet." Furthermore, under Paragraph H, DMS Standards of Conduct, this procedure states that "failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence. This paragraph also states falsification of records, documents, reports, logs, or statements constitutes a violation of standards.

Miami-Dade RJDC Facility Operating Procedure 7.01, Designated Health Authority (DHA)/Designee, DHA/Designee Admission Notification – This procedure states under Paragraph 12 that the DHA, in conjunction with the facility superintendent is responsible for the development, review and approval of all health related procedures and protocols to be used at the facility.

Record Reviews - During the course of the investigation, unless otherwise noted, the investigative team reviewed the following records:

Miami-Dade RJDC Shift Report for August 30, 2015, from 3:00 p.m. to 11:00 p.m. (*Exhibit 18*) – This report noted that youth [redacted] and four other youth were involved in a physical altercation on Module 9, at 5:30 p.m. on August 30, 2015. The report indicated current confinements and their status were discussed. In the narrative of the above physical altercation, youth [redacted] was listed as being confined; however, in other parts of the report, only youths [redacted], [redacted], and [redacted] were listed as being on medical confinement. There were no entries in the Superintendent/Assistant Superintendent Comments section.

Miami-Dade RJDC Shift Report from 11:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015 (*Exhibit 19*) – This report noted that current confinements and their status were discussed, although there was no indication of who was confined. Neither youth [redacted] first or last name were included in this report. Under the Superintendent/Assistant Superintendent Comments section, it indicated the report was reviewed, but did not indicate who reviewed the report.

Miami-Dade RJDC Shift Report from 7:00 a.m. to 3:00 p.m., August 31, 2015 (*Exhibit 20*) – This report noted that Thelon was the Shift Commander. As in the previous shift report, it indicated current confinements and their status were discussed, but did not indicate who was confined. Neither youth [redacted] first or last name were included in this report. Under the Superintendent/Assistant Superintendent Comments section, it indicated the report was reviewed, but did not indicate who reviewed the report.

Miami-Dade RJDC Shift Report for August 31, 2015, from 3:00 p.m. to 11:00 p.m. (*Exhibit 21*) – This report noted that current confinements and their status were discussed. It reflects that youth [redacted] was in medical confinement in Room 160, from 6:15 p.m., August 30, 2015, to 5:15 p.m., August 31, 2015. The report also showed JDO Murphy and JDO Hicks transported youth [redacted] to Jackson Memorial Hospital Holtz emergency room at an unspecified time, due to vomiting and nausea. JDOS Joshua Washington was listed as the Shift Supervisor. There were no entries in the Superintendent/Assistant Superintendent Comments section.

Confinement Report for youth [redacted] (*Exhibit 22*) – This report noted that youth [redacted] was placed into medical confinement on August 30, 2015, at 6:15 p.m. by JDOS Washington and the confinement was approved by then-Acting Assistant Superintendent Samuel Thelon. The report stated youth [redacted] was placed on medical confinement for "24 hours concussion precaution" per Nurse Beckford, and that youth [redacted] had been involved in a physical altercation. Thelon indicated he reviewed the report at 8:00 a.m. on August 31, 2015, and stated, "The youth will remain on medical confinement."

Video Surveillance of Module 9 from Camera 126 and Camera 128, and selected digital images (*Exhibits 6, 7, and 8, respectively*) – This video surveillance showed the assault on youth [redacted] by other youth in Module 9 and JDOS Johnson's and Valcin's response to the incident. The video showed JDOS Johnson and Valcin attempting to remove youth who were assaulting or surrounding youth [redacted]. As to the actions by the officers in response to the incident, there are no discrepancies with their response.

Youth Alert Notes Report for youth [redacted] (*Exhibit 23*) – This report noted that Nurse Beckford created an alert indicating youth [redacted] was placed on Concussions Precautions for 24 hours.

Excerpts from the Intake/Release Office (IRO) Logbook (*Exhibit 24*) – This logbook showed the following relevant entries:

- At 8:24 p.m., Green noted that JDOS Stephen Bronson was en route to the nurse's station with youth [redacted].
- At 8:34 a.m., Young noted that Superintendent Steve Owens and Thelon were en route to medical with youth [redacted].
- At 8:45 a.m., Young noted that Thelon was back in the IRO with one youth.
- At 9:13 a.m., Thelon noted that he conducted a status check in the IRO and reviewed the logbook.

Excerpts from the Module 9 Logbook (*Exhibit 5*) – This logbook showed the following pertinent entries:

- At 5:25 p.m., August 30, 2015 – A Code Blue was called after "youth [redacted] got involved in a physical altercation with several youth. . ." The entry indicates youth [redacted] was escorted off the module with no further issues.
- At 8:47 p.m., August 31, 2015 – All youth levels were dropped due to the fight on the module yesterday, per Sgt. Bronson and Major Owens.

Interviews - Unless otherwise noted, the investigative team conducted the following interviews, which were sworn and electronically recorded.

JDOS Shatara Chisolm (Witness)
Date of Interview: September 22, 2015

During her interview regarding another allegation, Chisolm stated the following: On the night of the incident, she and JDOS Bronson viewed the video of the incident in which youth [redacted] was attacked. Once she viewed the video, she said the police needed to be called. Bronson asked youth [redacted] twice if he wanted to call the police. According to Chisolm, the first time the youth said "yes," however, Bronson was trying to address some issues on other modules before making the call. When Bronson returned and asked the youth a second time, youth [redacted] said he did not want to call the police; he just wanted to kill all the youth. Chisolm said she did not know if Bronson contacted the Superintendent or one of the Assistant Superintendents.

Regional Director Gladys Negron
Date of Interview: January 6, 2016

Dr. Negron stated the following: When Thelon reviewed the Confinement Report for youth [redacted] at 8 a.m., and did not address the four and a half hour difference between McEady's review and Wallace's review; he failed to perform his duties. Likewise, Thelon was responsible for reading the Youth Alert Notes for youth [redacted] and knowing that the youth was to be awoken every two hours, if he was sleeping.

Dr. Negron further stated she understood why staff would not call law enforcement if the youth stated they did not want to press charges in certain matters. She said law enforcement would come and the youth would decline to speak to law enforcement, and that "it's a waste of a call to the law enforcement officer." She was not aware of any statewide or region guidance regarding calling law enforcement and concurred that this was an area that should be addressed. When asked about youth [redacted] initial response in which he indicated he wanted to call law enforcement, she responded that law enforcement should have been called at that time.

Assistant Secretary for Detention Services Dixie Fosler (Witness)
Date of Interview: January 14, 2016

Assistant Secretary Fosler was interviewed regarding the Department's philosophy and standards for notifying law enforcement pertaining to youth on youth assaults. She stated the following: She was not aware of any written standards addressing when law enforcement is to be called regarding youth on youth batteries in detention centers. She was unaware of what the practice was in the South Region regarding this issue, but advised that Detention Services would be addressing this issue statewide. A/S Fosler also agreed that Detention Services needed to develop guidance in this area and said Detention Services has already instituted a policy under which detention centers must report any incident involving three or more youth. Detention Services will then review the video surveillance and take appropriate action. *[Inspector's Note: Detention Services provided documentation related to this process. See Exhibit 49.]*

Superintendent Steve Owens (Subject)
Date of Interview: October 14, and December 21, 2015

Per the Secure Detention Rule, at the time of the incident, Superintendent Owens was responsible for ensuring compliance with all applicable laws, rules, regulations, policies, and procedures related to the operation of a secure detention facility and to the proper care, custody, and control of detained youths. He stated the following: He originally went to the Intake/Release Office (IRO) the morning of August 31, 2015, regarding a matter not related to youth [redacted]. While there, JDOS Chisolm advised him that youth [redacted] was in medical confinement, having been involved in a fight the day before. He said he spoke with youth [redacted], who complained about being at the detention center. He asked him if he wanted to file charges (regarding the assault) but youth [redacted] declined, stating he knew where the other youth lived and he wanted to kill them. When he asked youth [redacted] how he felt, youth [redacted] said he was sore, so he escorted him to see the nurse.

Owens stated that later, around 4:00 p.m. to 4:30 p.m.; he reviewed the video surveillance of the August 30, 2015, altercation on Module 9. He observed approximately 15 youth "appear" to attack youth [redacted], and that two youth were kicking youth [redacted], who was on the ground. He considered this action to be criminal in nature, but did not notify law enforcement nor did he know if law enforcement had been previously notified. He said law enforcement was notified after youth [redacted] died. Owens stated his experiences have been such that law enforcement would not pursue an incident if the victim declined to press charges, or if the victim was not at the facility. He added that he did not provide any medical staff with any description of what the video surveillance showed, regarding what happened to youth [redacted] in the module.

With respect to the transport of youth [redacted] to the hospital, Owens said that when he became aware that the Code White involved youth [redacted] (around 3:40 p.m.), he told Assistant Superintendent Thelon the youth was being transported to the hospital. Later, he went to speak to the nurse about the transport and thought the youth had already been transported. After he spoke with the nurse and was leaving the nurse's station (about 4:46 p.m.) he saw and spoke with youth [redacted]. *[Inspector's Note: The video surveillance showed Owens entered the nurse's station around 4:45 p.m. and appeared to have a conversation with JDO Glanville, youth* [redacted]*, or both of them, before he spoke with Nurse Adams.]* Owens said he did not know youth [redacted] was still in the building and told JDOS Bronson or JDOS Washington to get him out of the building. He said he might have been called and told the youth was still in the building. *[Inspector's Note: Owens fluctuated on where and when he learned the youth was still at the center, placing the time between 4:00 p.m. and 4:46 p.m.]* Owens stated that waiting for an officer to be relieved was not an acceptable reason for a delay in transporting youth [redacted] to the hospital.

When asked if he had ensured compliance with all applicable laws, rules, regulations, policies and procedures related to the operation of the facility and to the proper care, custody, and control of detained youths, Owens said he felt he did. He said there was no way he could know about everything that happened at the facility. He added that youth [redacted] was placed on medical confinement on Sunday (August 30, 2015), but he did not call to make sure the checks were being conducted. *[Inspector's Note: Owens was not questioned regarding his actions on August 30, 2015, because there was no information to indicate anyone had informed him about the incident prior to his arrival at the center on Monday, August 31, 2015.] Owens stated that* while the (Secure Detention) rule might identify him as responsible for the officers conducting the 10-minue checks; he did not feel responsible for that, as the officers knew what their requirements were.

In a follow up interview on December 21, 2015, Owens stated the following: There is no policy that states when law enforcement is to be called regarding a youth on youth battery. If the youth victim does not want to press charges, detention staff will not call law enforcement. Owens said he was not aware of any exceptions to this practice. As to Thelon's duties and responsibilities, Owens stated the assistant superintendent is to review the logbook on a weekly basis. Owens was not aware of how far back the assistant superintendent was required to review. He said that when Thelon reviewed the confinement report, he should have reviewed the report in its totality and should have noted the almost four and a half hour gap; however, he previously stated there was no written requirement for anyone to confirm that the supervisors were ensuring that the 10-minute checks were conducted. He added that everyone is required to review the youth alert notes and that if Thelon had been aware of the youth alert note, he would have been expected to follow up.

Assistant Superintendent Ell Fance (Subject)
Date of Interview: October 14, 2015

Assistant Superintendent Fance reviewed both PAR reports associated with the incident involving youth [redacted]. He stated the following: He was off Sunday, August 30, 2015, and Monday, August 31, 2015. On Monday evening, Superintendent Owens called him and told him about youth [redacted] death and he came into work. He did not review the video surveillance of the incident until the following day. By that time, Owens had told him that law enforcement had already been notified.

Assistant Superintendent Samuel Thelon (Subject)
Date of Interview: October 14, and December 22, 2015

Assistant Superintendent Thelon was identified in the Confinement Report, the IRO Logbook, and on the video surveillance as having contact with youth [redacted] on August 31, 2015. He has been employed with DJJ since August 2006, and recently (early October 2015) was promoted to assistant superintendent, after acting in that role for about a year. He stated the following: He worked from approximately 7 a.m. to about 5 or 6 p.m. on August 31, 2015. He reviewed the Confinement Report for youth [redacted], where it indicated the youth was placed on medical confinement for "24 hours concussion precaution." Thelon said he "probably" reviewed the shift report from 11:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015, and the shift report from 7:00 a.m. to 3:00 p.m., August 31, 2015. *[Inspector's Note: Thelon advised he stated that he "probably" reviewed the reports, because they contained comments that he normally writes on the reports.]*

Thelon further advised that he reviewed the logbook for the IRO, but said he "probably" only reviewed it for the current shift. *[Inspector's Note: Thelon again used "probably" and upon questioning, it appeared his practice was only to review the current shift.]* He added there is no time frame to conduct the review. When asked if he only reviewed the logbook for the current shift and not earlier shifts, he said assistant superintendents only review the logbooks once a week. He said he only reviewed the shift he was working. He added he never received any guidance that he was to review the logbook back to the previous time it was reviewed by the superintendent or an assistant superintendent. *[Inspector's Note: The historical practice has been to review the logbook back to the previous review. This ensures all entries are reviewed.]*

Thelon further stated that when he reviewed the Confinement Report for youth [redacted] at 8:00 a.m.; he only looked at part of the report. Initially, he said when he does his review of the Confinement Report; he does not look at the Supervisor's Comment section. He only looks at the first part of the report, indicating the reason why the youth was placed on confinement. Later during the interview, Thelon clarified his statement, saying that sometimes he checks the Supervisor's Comments. With respect to the Confinement Report regarding youth [redacted], Thelon said he did not review the comments by the supervisors. When shown the confinement report during the interview, he verified there

was a four hour and 27 minute difference between JDOS McEady's review at 2:00 a.m. and JDOS Wallace's review at 6:27 a.m. (The Rule states the review will be every three hours.) Thelon admitted that when he reviewed the report at 8:00 a.m., he did not review the supervisor's comments.

Thelon advised that the supervisors were responsible to make sure 10-minute checks were conducted. He said the assistant superintendents are responsible to verify that the supervisors are conducting their checks, which can be accomplished by reviewing video footage. When asked if he reviewed these on the video surveillance, he said this was not done every day and that there are random checks conducted. Thelon said he was not sure how the 10-minute checks could be verified, other than through the random reviews of the video surveillance.

Thelon acknowledged he did not read the Youth Alert Note for youth [redacted] and did not realize the youth was to be awakened every two hours, if he was sleeping. He also said he did not know how he could ensure this was being done if he never read the youth alert note.

Thelon said he spoke to youth [redacted] on the morning of August 31, 2015. Superintendent Owens and he went to the IRO to see a high profile youth. While in the IRO, he and Owens went to see youth [redacted]. The youth was frustrated, irate, and wearing only his boxers. When asked if he looked at the Visual Observation Report, Thelon said he was concerned about the youth, but he did not look at the VOR. He said he never checked to see if checks were conducted overnight.

Thelon further stated he reviewed the video surveillance of the Module 9 altercation around 4 p.m., August 31, 2015, along with Superintendent Owens. He observed youth [redacted] being jumped. He said after reviewing the video, he and Owens called in the supervisors and asked why they were not called and advised of the magnitude of the fight. He added that at no time, did they decide to call law enforcement. He acknowledged that the video showed a youth had kicked youth [redacted]. He also acknowledged the action was criminal in nature and said the supervisors should have called law enforcement. Thelon was unable to explain why he and Owens did not call law enforcement after viewing the video.

Thelon continued to state that a Code White was called involving youth [redacted], possibly right before he and Owens reviewed the video surveillance. Shortly afterwards, he and Owens talked about the youth going out to the hospital. He said he did not recall any conversations afterwards with Owens, concerning the youth leaving the facility and did not know an hour had elapsed before the youth was transported to the hospital. He said he felt youth [redacted] transport should have been quicker.

In a follow up interview on December 22, 2015, Thelon stated the following: With respect to calling law enforcement regarding youth on youth batteries, normally the detention staff

will not call if the victim youth does not want to press charges. He said he has not seen any situation that would change that procedure. He said he and Superintendent Owens viewed the video of the incident involving youth [redacted] and that law enforcement was still not notified, even after the youth had left the facility. He added he was not sure why law enforcement was not called and said the youth's decision on pressing charges was most likely the overriding factor. Thelon confirmed that shortly after the Code White was called, he and Owens talked about the youth going to the hospital. He did not recall the time this occurred. He said he saw the youth when he was about to be transported and spoke with him. Thelon said that time elapsed since the youth had been referred (3:40 p.m.) until he departed, did not register with him at the moment, as being too long.

JDO Supervisor Stephen Bronson (Subject)
Date of Interview: October 14, 2015

Bronson was identified in documents and through other testimony as the Shift Supervisor for the 3:00 p.m. to 11:00 p.m. shift for August 31, 2015. Video surveillance showed he had direct contact with youth [redacted] during this time. He stated the following: He responded to the Code Blue (on Module 9) and when he arrived, the fight was finished. He escorted youth [redacted] to medical, where the youth told the nurse that he was fine and that he wanted to retaliate against the other youth. The nurse said he was going to place youth [redacted] on concussion precautions and he was escorted upstairs (to the IRO) for medical confinement.

Bronson reviewed the video surveillance of the Module 9 incident. When shown the video during this interview, he confirmed he observed a youth kick youth [redacted]. Bronson admitted that the incident was criminal in nature, but said he did not notify law enforcement because youth fight all the time. He later stated this was not a normal fight and very seldom are there one-on-one fights. He said he called JDO Valcin and JDO Johnson in an attempt to identify the youth involved in the fight. He also suggested to youth [redacted] that he press charges. Bronson could not recall if youth [redacted] ever responded that he wanted to press charges, however, he later indicated the decision not to call law enforcement was based on what the youth said. When asked if he had an obligation to report the matter to law enforcement, Bronson acknowledged he did have an obligation to report the incident.

Bronson further stated that after reviewing the video surveillance, he returned to the IRO that evening and escorted youth [redacted] to the nurse's station. He said he was unaware of why he was taking the youth to see the nurse this second time, however, the youth told him that he was sore. He said he did not tell the nurse what the video showed and felt the nurse already knew that several youth had jumped youth [redacted]. Bronson fluctuated on whether he had an obligation to tell the nurse about what he observed on the video. He ultimately said he should have told the nurse and could not explain why he did not. He said he did not brief the incoming shift supervisor about the incident, but he thought JDOS Washington (the on-duty shift supervisor) was present when he was questioning Valcin

and Johnson about the inconsistencies between the PAR reports and the video surveillance.

Bronson stated he did not notify the superintendent or any assistant superintendent about the incident, however, Superintendent Owens questioned him around 3 p.m. on August 31, 2015, and they reviewed the video surveillance. According to Bronson, between 3:50 p.m. and 4:00 p.m., someone called Owens and told him youth [redacted] was being taken to the hospital. Owens told the person the youth needed to get out of the center "right this minute."

Conclusions/Recommendations - Based on documents reviewed and interviews, there is insufficient evidence to prove or disprove Superintendent Owens failed to perform his duties; therefore, the allegation of Improper Conduct against him is **NOT SUSTAINED**.

There is sufficient evidence to prove Assistant Superintendent Thelon and JDOS Stephen Bronson failed to fulfill their duties. Each of these staff were aware of the battery on youth [redacted], a criminal act, however, they failed to notify law enforcement. Furthermore, as youth [redacted] had stated he wanted to kill the other youth, there was potential jeopardy to both youth [redacted] and the other youth. At the time, there was no written policy addressing notification of law enforcement under these circumstances. Both Owens and Bronson were aware that youth [redacted] said he wanted to kill the other youth; however, there was no written guidance that addressed this subject. The circumstances of this case indicate there should be written guidance concerning notification of law enforcement under certain conditions. Therefore, this is determined to be a **POLICY DEFICIENCY**.

Assistant Superintendent Thelon failed to carry out several of his responsibilities. Specifically, he did not review supervisor comments on the confinement report and he did not read the Youth Alert Note for youth [redacted]. Reading the note would have alerted Thelon to the requirement that the youth was to be awakened every two hours. Therefore, the allegation of Improper Conduct against him is **SUSTAINED**.

JDOS Bronson also failed to perform his duties in that he did not notify law enforcement when youth [redacted] initially stated he wanted to press charges against the youth who assaulted him. While there was no specific policy addressing the notification of law enforcement, Bronson admitted he had an obligation to report the matter to law enforcement and to the nurse. FOP 1.09 states "failure to use ordinary or reasonable care, or the omission of, or inattention to, the performance of assigned duties and responsibilities" constitutes negligence. Bronson was aware the evening of August 30, 2015, of the assault on youth [redacted], however, he did not relay this information to the nurse. Furthermore, there was sufficient opportunity for Bronson to have at least informed Superintendent Owens of the details, when the two of them escorted youth [redacted] to the nurse's station the morning of August 31, 2015. Therefore, the allegation of Improper Conduct against Bronson is **SUSTAINED**.

Assistant Superintendent Fance was not at work at the facility from the time of the assault on Sunday, August 30, 2015, until after youth [redacted] death on Monday, August 31, 2015. He was unaware of the situation until Superintendent Owens called him and informed him about youth [redacted] death on Monday night. As a result, the allegation of Improper Conduct against Fance is **UNFOUNDED**.

IV. ADDITIONAL MATTERS

Other Investigative Activities

During the course of this investigation, the OIG determined there were additional matters, which should be brought to the attention of Detention Services as follows:

Revised Facility Operating Procedures (FOPs). The OIG reviewed several of the revised FOPs in effect at the Miami Dade RJDC after Detention Services issued standardized FOPs (*Exhibit 50*). The following are recommendations regarding several areas that might still require further clarification: *[Inspector's Note: Detention Services is in the process of changing some of these procedures.]*

FOP 1.13 Logbooks. This FOP states the Superintendent or designee shall review all logbooks at a minimum of weekly. While this provision was codified in Chapter 63G-2.018, Florida Administrative Code, at the time of the incident, there was some confusion on the part of Assistant Superintendent Thelon as to what this review entailed. It is recommended the FOP be clarified to read that Superintendents or designees will review the entries made since the last review.

FOP 2.03 Alerts. This FOP states, "JDO Supervisors shall read the detailed alert list aloud during shift briefings." A review of the shift report for 11:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015, showed the passing of alert information was documented in general, "Officers were advised to make sure they are reviewing the alert list for diets, gang members, no sports, single room only youths, mental health alerts, allergies, escape risks." Notably absent was the mention of specific medical-related actions to be performed by detention staff. The next shift report was even more general, "Alerts and their status were discussed." It is recommended this FOP be reviewed to determine whether more definitive guidance on the passing of alert information can be instituted and any alerts and important information documented, citing specific cases.

FOP 3.04, Medical Confinements. This FOP states that medical staff will obtain the Practitioner's order from the DHA or ARNP prior to any medical confinement. On October 23, 2015, Superintendent Owens stated this was done during some recent medical confinements. The new FOP states that a confinement report will be reviewed every three hours by the JDOS and every 24 hours by the Superintendent or designee, while the youth remains in medical confinement. It does not mandate that these reviews include checking to ensure that if 10-minute checks are being conducted and documented. Owens also confirmed that this FOP does not mandate checking of the VORs by supervisors. The FOP further states the youth will be observed throughout the medical confinement and this will be documented using the facility's security 10-minute check system. Officers must observe the youth moving and/or breathing, and "the observation will be

documented on the [visual observation record] VOR." When asked for a copy of the associated VOR, Superintendent Owens provided a copy of the current VOR (*Exhibit 51*), which was identical to *Exhibit 25*. This VOR, which was in effect at the time of youth [redacted] medical confinement, included no area for officers to properly document their observations. Without a specific space to document the observation, it is questionable how this requirement would be met. It is recommended that the language and supporting documents for this FOP be reviewed and clarified as necessary. It is also recommended the FOP be clarified as to who is responsible for what actions. For example, "Officers will document their observations on the VOR," instead of "the observations will be documented on the VOR." Using the active voice clearly defines who is responsible for the action.

FOP 3.11, Room Checks/Supervision Levels. This FOP states that when a youth is placed in a room, whether for sleeping or other reasons, officers shall conduct visual observations to ensure safety and security. It also states that written visual observations shall be documented, to include the time of the observation and the initials/identification of the officer completing the observation. This specific language reinforces the past practice of just documenting times and initials, which appears to be counter to the provisions of FOP 3.04, which directs the documentation of specific observations. The FOP also permits electronic documentation for facilities using electronic cell check systems. This also appears to be contrary to the provisions of FOP 3.04. Superintendent Owens stated this FOP would also apply to medical confinements. It is recommended this FOP be clarified, to remove conflicting language with FOP 3.04.

FOP 4.05, Transportation and Security During Hospital Stays or Medical Treatment. This FOP addresses the transportation of youth to off-site medical facilities for emergency care. While it includes procedures specific to the transport of a youth by a contracted ambulance service, it does not include procedures for the transport of youth by a state vehicle or by 911. A review of FOP 4.06, Transportation Procedure, showed it addressed procedures for the transport of youth by a State vehicle; however, that FOP seemed to address regular medical appointments and not emergency care needs. Neither FOP addressed who makes the determination if a state vehicle or contracted ambulance service is used. On October 23, 2015, Owens confirmed there was no FOP that addressed who or how this determination is made. It is recommended these FOPs be reviewed and more definitive guidance be developed, in coordination with DJJ/OHS.

Clinical Medical Confinement Protocols. The OIG noted that a portion of the lobby area of the nurse's station had been cordoned off (see *Exhibit 52)*. Superintendent Owens provided a copy of the draft Clinic Medical Confinement Protocols (*Exhibit 53)*, which reportedly were being reviewed by Regional Director Gladys Negron. Owens said he does not know if DJJ/OHS coordinated on the protocols. It is recommended DJJ/OHS

coordinate on these protocols, to ensure that this new system adequately addresses medical confinement requirements.

Limitations of the current nursing protocol for head injuries. During the course of this investigation, the OIG identified some concerns with the current nursing protocol for head injuries *(Exhibit 43)*. The OIG raised the following concerns to Correct Care Solutions (CSS), the contracted provider. Included are CCS's responses and the OIG assessment and are outlined below:

- The protocol states there should be continued neurovascular assessments and vital signs every two hours, done twice, then every four hours for 24 hours.

  - Concern: What if after the first neurovascular assessment and vital signs check the only medical staff on duty is busy with other patients and cannot complete the second check until three hours after the first assessment?

    CSS Response: As with all patient care, nurses must prioritize which patient needs to be seen first based on the acuity presentation at that time.

    OIG Assessment: This seems to be a reasonable response.

  - Concern: What if there is no medical staff on duty after the first two assessments are completed and it's now time for the first check at four hours?

    CSS Response: The protocol governs those times when nursing staff is in the facility. Officers do not complete neurological checks but can contact an on-call doctor as needed. Otherwise, the nursing assessments would continue when the next nursing shift commences. It would be in the judgment of the nurse leaving their shift to determine if the patient's condition presented a need to call the on-call doctor at that time and discuss the status of the patient.

    OIG Assessment: It would appear the reasonable course of action would have been for Nurse Beckford to call the DHA to determine what, if anything should have been done. It is recommended this matter be reviewed by DJJ/OHS, and referred to the Florida Board of Nursing.

- The protocol instructs the medical doctor is to be notified of all head injuries.

  - Concern: Is there a specific time in which the medical doctor must be notified after the medical staff becomes aware of or suspects a head injury?

    CSS Response: The protocol does not contain a specific time frame. The acuity of the patient may impact the time in which the nurse contacts the physician.

OIG Assessment: It is recommended this matter be reviewed by DJJ/OHS. It would seem reasonable to establish some guidance on timely notification of the doctor.

- Concern: What constitutes notification of the medical doctor? For example, if there is a list of patients to be seen by the doctor the next time he or she is at the facility, does putting the patient's name on this list constitute notification? What if the doctor does not know who is on the list and for what reason, until they arrive at the facility, has the requirement for notification been satisfied?

  CSS Response: Notification to the doctor would typically be a telephone call.

  OIG Assessment: Adding a youth's name to a list does not constitute a reasonable definition of notification. It is recommended this matter be reviewed by DJJ/OHS.

- Concern: What if a patient is already on the list for some routine reason and has yet to be seen by the doctor, does their being on the list satisfy the requirement for notification?

  CSS Response: Every situation is unique. However, in this particular instance, no.

  OIG Assessment: Nurse Beckford failed to follow nursing protocol, in that he did not notify the doctor. It is recommended this matter be reviewed by DJJ/OHS, and referred to the Florida Board of Nursing.

Review of Shift Reports. A review of two of the four shift reports covering the incident period showed there was no entry in in the Superintendent/Assistant Superintendent Comments section. The other two shift reports indicated the report was reviewed; however, it did not indicate who reviewed the report. Assistant Superintendent Thelon stated he normally reviewed shift reports; however, when shown the shift reports for the 3:00 p.m. to 11:00 p.m. shifts on August 30 and 31, 2015, Thelon stated he did not review the reports. When shown the shift report from 11:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015, Thelon stated he probably reviewed the report. He also stated he probably reviewed the shift report from 7:00 a.m. to 3:00 p.m., August 31, 2015. The OIG could not find definitive guidance in the Secure Detention Rule as to who must complete the Superintendent/Assistant Superintendent Comments section, and by when. It is recommended Detention Services clarify this matter and issue appropriate and specific guidance to all detention centers.

Completion of the PAR Reports/Incident Reports. The two PAR Reports associated with this incident did not accurately reflect what specifically occurred. The reports made it appear there was an altercation between youth [redacted] and a few youth, not that almost

the entire module of youth participated in the assault in some manner. JDOS Bronson stated he had to call JDO Johnson and JDO Valcin to have them rewrite their explanations of the incident. Even still, the PAR reports did not accurately reflect what is seen on the video surveillance. As JJIS allows for the populating of similar fields in the incident report, the narratives that were included in the incident report also do not accurately portray what actually occurred. As medical staff normally do not review video surveillance showing the magnitude of fights, it is critical that the written report specifically details what occurred.

While it is speculative as to what actions might have been taken had the nurses known of the severity of the strikes against youth [redacted], the fact is the majority of the evidence indicated they were not aware of the magnitude of the fight. One of the established roles for medical staff per the PAR Rule, is to "to determine [via the Medical Review], from a medical perspective, if injuries or complications occurred as a result of the physical intervention or application of mechanical restraints, and if the youth requires further medical treatment" [Chapter 63H-1.007, FAC, Paragraph (2)(d)2.]. It is recommended that Detention Services and Regional staff re-emphasize the importance of writing accurate and concise narratives to reflect what occurs during incidents. It is further recommended that Detention Services, DJJ/OHS, and other appropriate offices consider how best to ensure medical staff can provide medical treatment that is based on the totality of the situation.

Multiple Terms for Medical Confinement. Detention Services issued a directive in March 2015, directing the use of the term "medical confinement" for any youth who is placed in a room for a medical or sick reasons. However, there is a continued use of multiple terms at the Miami-Dade RJDC. The IRO logbook used both "confinement" and "bedrest" in a manner in which it appears both terms have some deliberate meaning or distinction, as opposed to them just being used interchangeably. In reviewing medical documentation, no such documents were found that originated from the medical/nursing staff, which indicated the medical/nursing staff placed the youth on "medical confinement." The Youth Alert Notes and the initial Post-Par Medical Review progress note indicated he was placed on Concussions Precautions. The second Post-Par Medical Review progress note indicated he was "currently on medical confinement and concussions precautions." When questioned about this, Superintendent Owens advised that the center follows the March 2015 directive, but since terms like "bedrest" had been used before there is a continued use, which management attempts to correct by directing staff to use the correct term "medical confinement." It is recommended Detention Services and Regions re-emphasize the use of standardized critical terms.

Time Sheet – Assistant Superintendent Ell Fance (*Exhibit 54*). During his testimony regarding Allegation #5, Fance testified he was off August 30-31, 2015, but that on Monday evening, Superintendent Owens called him and told him about youth [redacted] death. Fance stated he came into work. From the original CCC report, youth [redacted] death was established at approximately 11:05 p.m., August 31, 2015. To determine when Fance was present at the Miami-Dade RJDC on August 30-31, 2015, the OIG reviewed

his People First documentation and other records. Fance indicated on his People First time sheet that he worked 11.0 hours on August 31, 2015, which appeared to be inconsistent with his testimony. Inspector Bodnar interviewed Superintendent Owens on October 23, 2015, as the People First system showed Owens approved Fance's time sheet on September 11, 2015. Owens stated the hours reflected were for different days; however, Fance's profile at the time did not allow him a flex schedule option. Owens provided supporting documentation to reflect this situation and the corrective action (*Exhibit 55).* No further action is required.

JJIS Issue. The OIG noted that several of the shift reports did not document youth [redacted] as being confined. Assistant Superintendent Thelon stated the JJIS is a hit or miss, indicating that sometimes JJIS showed all confinements and sometimes it only showed confinements began or ended during the shift. Preliminary discussions with DJJ staff revealed the JJIS should be automatically populating data from confinement reports into the shift reports. It is recommended that Detention Services and Management Information Systems (MIS) review this matter to determine if there is a glitch in the system.

Coordination with Law Enforcement/Other Agencies

Immediate contact was made with Detective Oscar Andino, Miami-Dade Police Department (MDPD), the lead detective investigating the assault on youth [redacted]. It was agreed that the OIG investigative team would not interview youth due to the concurrent criminal investigation (PD150901326506).

On October 1, 2015, Detective Andino advised there was no pending criminal investigation targeting any Miami-Dade RJDC staff.

On October 14, 2015, at their request, the investigative team briefed officials from the United States Attorney's Office, Miami, and the Miami Field Office of the Federal Bureau of Investigation.

On October 15, 2015, at their request, the investigative team briefly discussed this case with officials from the State Attorney's Office and the Florida Department of Law Enforcement (FDLE).

On November 30, 2015, Detective Andino advised the investigation was still open. As of the date of this report, the case remains open.

A check of the Florida Department of Children and Families' FSFN showed their investigation (#2015-233478) was still in progress as of the date of this report. On December 4, 2015, Inspector Bodnar met with Child Protective Investigator Supervisor Leaford McCleary and briefly discussed this case.

Coordination with Management

Coordination with management was conducted throughout this investigation via updates from the Inspector General to the Secretary, DJJ, as appropriate and necessary.

V. EXHIBITS

1. CCC Incident Complaint Report #2015-04674
2. Timeline of events
3. PAR Report for youth [redacted]
4. PAR Report for youth [redacted]
5. Excerpts from the Module 9 Logbook
6. Video Surveillance of Module 9 from Camera 126
7. Video Surveillance of Module 9 from Camera 128
8. Digital Images from Cameras 126 and 128
9. Video Surveillance of Module 9 from Camera 125
10. Digital Images from Camera 125
11. Video Surveillance of Module 9 from Camera 126
12. Digital Images from Camera 126
13. Miami Dade RJDC Incident Report 201508300020
14. Incident Report on Recreation Field incident
15. Video Surveillance of Cafeteria – Part I
16. Video Surveillance of Cafeteria – Part II
17. Former JDO Valcin's Resignation
18. Miami-Dade RJDC Shift Report for August 30, 2015, from 3:00 p.m. to 11:00 p.m.
19. Miami-Dade RJDC Shift Report from 11:00 p.m., August 30, 2015, to 7:00 a.m., August 31, 2015
20. Miami-Dade RJDC Shift Report from 7:00 a.m. to 3:00 p.m., August 31, 2015,M
21. Miami-Dade RJDC Shift Report for August 31, 2015, from 3:00 p.m. to 11:00 p.m.
22. Confinement Report for Youth [redacted]
23. Youth Alert Notes Report for youth [redacted]
24. Excerpts from the Intake/Release Office (IRO) Logbook
25. 10 Minute Visual Observation Report
26. Selected digital images from the video surveillance of the IRO
27. Dismissal Letters - Joshua Washington
28. Dismissal Letters - Jeremy Dollard
29. Dismissal Letters - Marquise McEady
30. Proposed Dismissal of Demetrius Randolph
31. Proposed Dismissal of Utanda Green
32. Sick call request for youth [redacted]
33. Addendum to FOP 3.03, Confinement
34. Addendum to FOP 3.11, Room Checks/Supervision Levels
35. Digital image of youth [redacted] in IRO lobby area
36. Nursing Protocols
37. Post-PAR Medical Review
38. Code White Progress Note
39. Emergency Referral for youth [redacted]
40. Nurse Logbook
41. Nursing Shift to Shift Report

42. List of youth to be seen by the doctor
43. Email to Correct Care Solutions re Nursing Protocol for Head Injuries
44. Excerpt from Master Control Log
45. Video Surveillance of nurse's station – Afternoon of August 31, 2015
46. Selected digital images from the nurse's station
47. Excerpts from Jackson Memorial Hospital Documentation
48. Authorization to Consent for Treatment
49. HQ Notification Form
50. Selected revised Miami Dade RJDC FOPs
51. Current visual observation report
52. Photographs of the Clinic Medical Confinement Area
53. Draft of Clinic Medical Confinement Protocols
54. Assistant Superintendent Fance's People First time sheet
55. Email from Supt. Owens re Fance's time sheet

VI. STATEMENT OF ACCORDANCE

Section 20.055, Florida Statutes, establishes an Office of Inspector General in each state agency to provide a central point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency in government. In carrying out the investigative duties and responsibilities specified in this section, each inspector general shall initiate, conduct, supervise, and coordinate investigations designed to detect, deter, prevent, and eradicate fraud, waste, mismanagement, misconduct, and other abuses in state government.

All OIG personnel have completed appropriate documentation regarding their conduct as set forth by the OIG Investigations Independence Statement. The investigation was conducted in accordance with guidance from the Associations of Inspectors General handbook.

VII. DISTRIBUTION LIST

Action Official Distribution:

This report is distributed with all exhibits and attachments for action to:
Dixie Fosler, Assistant Secretary for Detention Services

Information Distribution:

Copies of the Executive Summary, without exhibits or attachments, have been distributed electronically to:
Christina K. Daly, Secretary
Timothy Niermann, Deputy Secretary
Fred Schuknecht, Chief of Staff
Heather M. DiGiacomo, Director of Communications

Files:

The original of the complete report has been placed in the Investigation File.