DEPARTMENT OF JUVENILE JUSTICE

OFFICE OF THE INSPECTOR GENERAL
BUREAU OF INVESTIGATIONS

REPORT OF INVESTIGATION
IG # 11-0048
CCC # 2011-02105

PALM BEACH REGIONAL JUVENILE DETENTION CENTER
1100 45th STREET, BUILDING 'A'
WEST PALM BEACH, FL 33407

OCTOBER 16, 2012

INTERIM INSPECTOR GENERAL: MARK PEREZ
CHIEF OF INVESTIGATIONS: KEITH W. MORRIS
FORMER INSPECTOR SPECIALIST: CHAD A. SCHEELEY

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I. INVESTIGATIVE PREDICATE

On July 10, 2011, former Juvenile Justice Detention Officer Supervisor (JJDO) Terence Davis of Palm Beach Regional Juvenile Detention Center (Palm Beach RJDC) notified the Department of Juvenile Justice (DJJ) Office of the Inspector General (OIG) Central Communications Center (CCC) that youth Eric Perez died at 8:10 a.m., while in medical confinement. Palm Beach RJDC is a state-operated detention program. It is located in Circuit 15, West Palm Beach, Palm Beach County, Florida.

On August 10, 2011, Investigations Coordinator Teresa Michael of the OIG identified during a review of video surveillance from Palm Beach RJDC recorded on July 9, 2011, JJDOs Darrell Smith and Alberto Rios conducted improper searches and participated in what appeared to be horseplay with youth Eric Perez and other unidentified youths while JJDO Christian Lewis observed. This horseplay was considered as a possible contributing factor to youth Perez's injury and death.

On August 10, 2011, West Palm Beach Police Department Homicide Detective Raymond Shaw requested the OIG suspend any interviews of staff/youth concerning the death of youth Perez until the criminal investigation is completed.

Autopsies performed on youth Perez determined his cause of death to be from a cerebral hemorrhage.

During the Winter Term 2012, the Office of the State Attorney for the Fifteenth Judicial Circuit of Florida made a presentation regarding the death of youth Eric Perez while in the custody of the Florida Department of Juvenile Justice to the Palm Beach County Grand Jury.

> The purpose of [the presentation to] this Grand Jury was to carefully examine the policies and procedures of the DJJ, particularly through its operation of the Juvenile Detention Center in Palm Beach County, and to evaluate the conduct of the officers responsible for [youth] Mr. Perez.[1]
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> * * *

The Grand Jury considered any criminal behavior or acts by DJJ staff as relating to youth Perez's cause of death; however, cited the lack of appropriate criminal sanctions, to wit - *no applicable statute exists criminalizing the actions and perhaps more importantly the lack of actions of the officers involved in the death of youth Perez.*[2] The Grand Jury also citing youth Perez's age (18 years old) at the time of his death prevented a consideration of the crime of child abuse or neglect, as a criminal charge.

Additional information and recommendations by the Grand Jury will be referenced in continuance of this report.

II. DOCUMENTS/EXHIBITS

The following documents/exhibits pertaining to alleged administrative violations were obtained during this administrative investigation. Investigative Coordinator Teresa Michael, former Inspector Specialist Chad Scheeley and Chief of Investigations Keith W. Morris reviewed the documents and noted the following:

[1] Presentment Regarding the Death of Eric Perez While in the Custody of the Florida Department of Juvenile Justice, Presentment of the Palm Beach County Grand Jury, Winter Term 2012.
[2] *Id.*

- Probation Medical and Mental Health Clearance Form for youth Perez - A review of this record showed a completion date of June 28, 2011, at 11:01 p.m. Based on the results, youth Perez was accepted to the Juvenile Assessment Center for standard screening.

- Secure Detention Admission Wizard for youth Perez - A review of this record showed youth Perez was admitted to Palm Beach RJDC on June 29, 2011, at 3:06 a.m. Neither youth Perez nor his mother (via telephone) expressed any medical or mental health concerns during the admission process.

- Medical and Mental Health Admission Screening for youth Perez - A review of this record showed that during the admission process on June 29, 2011, youth Perez denied having any medical or mental health conditions and denied he was currently prescribed medications.

- Medical and Mental Health Screening Form Attachment for youth Perez - A review of this form showed that during the admission process on June 29, 2011, youth Perez denied sustaining any head injuries during the previous two weeks. Youth Perez also denied having hemophilia (bleeding disorder).

- Sick Call Request for youth Perez - A review of this record showed a Sick Call Request was submitted on June 29, 2011, due to youth Perez expressing he was lactose intolerant. Registered Nurse Diana Heras completed the assessment and planned to alter youth Perez's nutritional status pending verification of needed information.

- Sick Call Index for youth Perez - A review of this record showed youth Perez requested medical attention on one occasion. The request was made on June 29, 2011, and was for "Allergy; Lactose."

- Health-Related History (HRH) Form for youth Perez - A review of this record showed a completion date of June 30, 2011. Youth Perez denied experiencing any of the medical symptoms covered by the HRH.

- Comprehensive Physical Assessment (CPA) for youth Perez - A review of this record showed a completion date of June 30, 2011. The Designated Health Authority (DHA) examined youth Perez and assigned a medical grade of "1" (low medical need).

- Doctor's Progress Notes - A review of this record showed that on June 30, 2011, after the CPA was complete, the DHA recommended youth Perez be evaluated by a dentist.

- Chronic Condition Notification for youth Perez - A review of this record showed a completion date of June 30, 2011. Youth Perez was documented as being lactose intolerant.

- Medical Progress Notes for youth Perez - A review of this record showed youth Perez completed orientation to medical care access. The record also reflects no "chronic illness" or "meds with youth." On July 10, 2011, at 7:45 a.m., Licensed Practical Nurse [Marcia] Clough was told by a supervisor that youth Perez was in medical confinement for vomiting through the night. At 7:51 a.m., Clough observed youth Perez was snoring. At 7:55 a.m., a "code white" (medical emergency) was called and Clough responded and observed four officers in the room and two officers outside. The AED (Automated External Defibrillator) was in place. One officer was performing rescue breathing and one was performing chest compressions. The machine advised to move away for analysis and reported, "No shock advised." Clough took over chest

compressions until EMT (Emergency Medical Technician) arrived at 8:00 a.m. While the EMTs attached their machine, an officer took over chest compressions. The EMTs' machine got a flat line and they said there was nothing they could do and that the police would take over from there.

- Confinement Report - A review of this record showed that on July 10, 2011, at 5:40 a.m., youth Perez was placed in room D-4 for medical confinement by JJDO I Christian Lewis, who has been "vomiting all morning and not feeling well." Davis conducted a confinement check at 6:24 a.m. and noted youth Perez was sleeping. A notation at 8:48 a.m. by Davis reflects, "youth is deceased in the confinement cell."

- Incident Report by JJDO II Floyd Powell, dated July 10, 2011 - A review of this record showed that while Powell was alone in the module and conducting room checks of the youths, he heard noise coming from room # 11. Powell approached the door and observed youth Perez crying and acting as if something was wrong with him. Powell immediately called Davis. Davis entered the mod and observed youth Perez screaming out loud, saying, "it hurts." Davis informed Powell that he was placing youth Perez on the dayroom floor for the night. At approximately 2:15 a.m. Powell observed youth Perez start to vomit, as he was asleep. Powell called Davis back to the module. Davis entered the module and observed youth Perez vomiting from his mouth and nose. Powell told Davis that he was going to call 9-1-1, but Davis responded "no." Davis stated it is not a life-threatening situation. Davis stated "he [youth Perez] will be ok once he gets whatever it is out of his system."

- B-2 Module logbook entries for July 9, 2011 – References to this review will be noted within this investigative report.

- B-2 Module logbook entries for July 10, 2011 - References to this review will be noted within this investigative report.

- Master Control logbook entries from July 10, 2011 - References to this review, will be noted within this investigative report.

- Written statement from Licensed Practical Nurse Marcia Clough, dated July 10, 2011 - A review of this record showed that at approximately 7:45 a.m. on July 10, 2011, Clough was approached by Davis, who stated there was a youth [Perez] in medical confinement because he vomited during the night. Davis stated to Clough that youth Perez exhibited "bizarre behavior" at approximately 3:00 a.m. and vomited a piece of hot dog and paint chips. Clough checked youth Perez at approximately 7:51 a.m. and noted snoring sounds. Clough was conducting sick call at approximately 7:55 a.m. when she heard a code being called, but didn't hear what type of code. Two minutes later, an officer told Clough it was a "code white." Clough responded to the medical confinement cell and observed two officers had applied the AED (Automatic External Defibrillator) machine to youth Perez and were performing CPR (Cardio-pulmonary Resuscitation). Youth Perez had a clear fluid coming from his mouth. The EMT (Emergency Medical Technician) arrived at approximately 8 a.m., analyzed youth Perez, and stated there was nothing that could be done.

- Written statement from former Superintendent Anthony Flowers dated July 10, 2011 - A review of this record showed that at approximately 2:39 a.m. on July 10, 2011, Flowers received a telephone call from Davis, who stated youth Perez had woke up stating, "get him off me." Davis stated he talked to youth Perez, calmed him down, and kept him on the dayroom floor to sleep, during which time the youth threw up. Flowers informed Davis to contact the facility nurse [Registered Nurse Diana Heras]. At approximately 3:09 a.m., Flowers received another call from

Davis stating he was not able to contact Heras and the youth was sleeping on the floor with an officer watching him. At approximately 8:10 a.m., Flowers received a call about the paramedics being at the facility for youth Perez. Flowers called the facility back and I was informed youth Perez passed away.

- Collected photographic evidence from youth Perez's room (# 11), the B-2 module, the B-2 sub-control room, and confinement room # D-4 - These photographs are as follows:

    - Photo # 1: Sink and mirror inside room # 11.
    - Photo # 2: Close-up of mirror showing scraped/peeled paint.
    - Photo # 3: Close-up of sink showing presence of paint chips.
    - Photo # 4: Room # 11 door with section of scraped/peeled paint.
    - Photo # 5: Close-up of room # 11 door showing scraped/peeled paint.
    - Photo # 6: Floor of room # 11 showing presence of paint chips.
    - Photo # 7: "Emergency Use of 9-1-1" poster in the B-2 module.
    - Photo # 8: "Emergency Use of 9-1-1" poster in the B-2 module's sub-control room.
    - Photo # 9: First-aid kit sitting in medical confinement room D-4, where youth Perez was housed.

- Video surveillance of the B-2 module - References to this review, if applicable, will be noted within this investigative report.

- Video surveillance of confinement room # D-4 - References to this review, if applicable, will be noted within this investigative report.

- Electronic room check logs for the B-2 module from July 9-10, 2011 - A review of this record showed on July 9, 2011, 10-minute room checks were conducted from 7:01 p.m. to 7:32 p.m., and from 9:18 p.m. to 11:59 p.m. The record also showed 10-minute room checks were conducted on July 10, 2011, from 12:08 a.m. to 7:39 a.m.

- Electronic room check logs for the D-4 confinement room from July 10, 2011 - A review of this record showed a total of 10 room checks were conducted between 6:21 a.m. and 7:45 a.m. Two checks were conducted beyond the required 10-minute time frame. A check conducted at 6:32 a.m. was at 11 minutes, and a check conducted at 7:19 a.m. was at 14 minutes.

- Training documentation consisting of sign-in sheets and CORE account printouts. A review of these records covering July 2010 to July 2011 showed the following:

    - Davis completed "9-1-1/Accessing Emergency Medical Services" and "Episodic and Emergency Care" trainings on July 23, 2010 and October 21, 2010, and participated in a mock medical drill on January 12, 2011.

    - Jarrell completed "9-1-1/Accessing Emergency Medical Services" and "Episodic and Emergency Care" trainings on September 8, 2010 and October 21, 2010, and participated in a mock medical drill on August 14, 2010, January 12, 2011 and April 12, 2011.

    - King completed "9-1-1/Accessing Emergency Medical Services" and "Episodic and Emergency Care" trainings on October 26, 2010 and April 20, 2011.

- Lewis completed "9-1-1/Accessing Emergency Medical Services" and "Episodic and Emergency Care" trainings on September 9, 2010, October 27, 2010, and April 20, 2011. Lewis also completed "Promoting Professional & Appropriate Staff Conduct (Parts 1 & 2)" on February 19, 2011, and completed "Safety and Searches" on March 31, 2011.

- Powell completed "9-1-1/Accessing Emergency Medical Services" and "Episodic and Emergency Care" trainings on September 8, 2010, October 23, 2010, and April 20, 2011, and participated in a mock medical drill on January 12, 2011 and April 12, 2011.

- Written statement from Registered Nurse Diana Heras, dated July 13, 2011 - A review of this record showed that on the morning of July 10, 2011, Heras noticed her phone had missed calls from 2:46 a.m., 2:51 a.m., and 3:05 a.m. There were two voice mail messages requesting Heras call the Palm Beach RJDC. One message was from Davis and the second was from an unknown staff (possibly Powell). Heras did not retrieve the messages until 7:30 a.m. Heras spoke with Davis at 7:39 a.m. and learned that a youth [Perez] had vomited during the night, stopped and seemed better. Youth Perez was placed in medical confinement and went to sleep. Heras instructed Davis to have the weekend nurse evaluate youth Perez and to ask her to call Heras.

- Incident Report by Lewis, dated July 10, 2011 - A review of this record showed that on July 10, 2011, at approximately 2:19 a.m., Lewis returned to the B-2 module. Upon entering, youth Perez was placed on the DRF (dayroom floor) by Davis. While sitting in the module, Lewis observed youth Perez start to vomit in his sleep. Youth Perez sat up and continued to vomit out of his mouth and nose. Lewis and Powell asked Davis if they should call 9-1-1, and Davis said "yes," but then told them not to call and to let him call Flowers first. Davis returned to the module and stated that Flowers told him not to call 9-1-1 and to call nurse Heras and let her "guide" him in the steps to take. Youth Perez kept moving around while sleeping, so they thought he would be all right after vomiting. At 5:00 a.m., Powell and Davis tried to wake up youth Perez so he could go take a shower, but he did not respond. Davis asked Lewis to do a medical confinement report. At 5:40 a.m., Lewis and Davis pulled youth Perez to the D-4 confinement cell while he was on the mat. At 6:55 a.m., Lewis checked youth Perez and observed him snoring and breathing. Lewis departed Palm Beach RJDC at 7:00 a.m.

- Incident Report by JJDO II Marlon Jarrell, dated July 10, 2011 - A review of this record showed that Jarrell went to the B-2 module before going on his break. While Jarrell sat at a table with Powell and Lewis, he observed youth Perez start to vomit while he was asleep on the dayroom floor. Powell called for Davis to report to the module. When Davis arrived, he just watched as the youth sat on his mat and vomited. Powell asked Davis to call 9-1-1, but he didn't. Davis and Powell picked up youth Perez off the floor to escort him to the shower, but his body was limp and he could not move by himself. Youth Perez began to vomit again. Powell then proceeded to call 9-1-1, but Davis said "no." Davis told Powell that youth Perez would feel better once he finished vomiting. Davis told Powell it is not an emergency situation. Jarrell told Davis to call Flowers. Davis exited the module to go make the call.

- Incident Report by JJDO I Laryell King, dated July 10, 2011 - A review of this record showed that on July 10, 2011, at approximately 5:33 a.m., King was instructed by Davis to sit in front of the D-4 confinement cell with the door open and to observe youth Perez. At 6:16 a.m., Davis instructed King to start 10-minute room checks. At approximately 6:30 a.m., King proceeded to her assigned module.

- Incident Report by Davis, dated July 10, 2011 - A review of this record showed that on the morning of July 10, 2011, Davis was getting ready to end his shift and decided to check on youth Perez in the confinement cell. Davis approached the door and did not hear youth Perez snoring, as he was throughout the night. Davis immediately ran into the cell to check youth Perez's pulse on his neck and wrist. Davis noted the pulse was very weak. Davis called a "code white," along with 9-1-1 and Flowers. Davis and Roberts performed chest compressions and mouth-to-mouth resuscitation. The paramedics arrived at 8:09 a.m., checked youth Perez, and pronounced him dead.

- Incident Report by JJDO II Randolph Roberts, dated July 10, 2011 - A review of this record showed that on July 10, 2011, at approximately 7:50 a.m. a "code white" was called at the D-4 confinement cell. Roberts responded and found youth Perez lying on a mat on the floor. Roberts and Davis unsuccessfully attempted to wake up youth Perez. Roberts and Davis then placed youth Perez on the concrete slab. Roberts and Davis determined youth Perez was not breathing and continued to be unresponsive. Roberts started CPR while Davis retrieved the defibrillator. The defibrillator advised "no shock." Roberts checked youth Perez for a pulse and did not find one. Roberts and Davis then resumed CPR. Clough arrived to assist. The defibrillator stated "no shock" a second time, so they continued CPR. The West Palm Beach Fire Department arrived to assume care of youth Perez.

- Incident Report by JJDO I Lydia Sanchez, dated July 15, 2011 - A review of this record showed that Sanchez was assigned to the B-1 module on the morning of July 10, 2011. Sanchez did not have any direct knowledge of the situation in the B-2 module, but indicated that Davis entered the B-1 module three times to "state his opinion of the situation." Around 1:40 a.m., Davis stated a youth [Perez] was "acting crazy," hearing voices, banging on the door, and screaming. About an hour later, Davis returned and stated youth Perez was still acting up. Davis stated he felt youth Perez "was trying to go to Columbia Hospital to escape." Davis stated youth Perez was friends with another youth who had just come back from Columbia Hospital a couple of weeks ago and they talked about how easy it was to escape. Davis stated youth Perez was upset that his family would not pick him up. Davis returned an hour later and stated youth Perez seemed "unaware and lost." Davis returned to the B-1 module the third time and stated youth Perez appeared to be "high from eating paint." Davis stated youth Perez just needed to rest and sleep. Davis stated Flowers was informed of the situation.

- Incident Report by JJDO I Mismaille Souffrant, dated July 15, 2011 - A review of this record showed that Souffrant was assigned to the B-3 module on the morning of July 10, 2011. At approximately 1:30 a.m., Souffrant heard Powell call Davis over the radio and ask him to report to the B-2 module immediately. At approximately 2:00 a.m., Souffrant was walking to the B-2 module to see what had happened when she met Lewis in the hallway. Lewis stated to Souffrant that a youth [Perez] in room # 11 was saying he heard voices, so Davis put him on the dayroom floor for the night. As Souffrant talked to Lewis, Davis arrived and started talking to Lewis. Davis stated to Lewis that he thought youth Perez "was faking his sickness so he could go to Columbia Hospital to escape because his parents did not want him." Souffrant further wrote, "If you review the main hallway camera by the clock, it will show (supervisor) Davis showing how the youth was faking his sickness." Davis stated he was not taking the youth to Columbia Hospital because he "was not going to complete a CCC report." At approximately 3:00 a.m., Souffrant was at the door of the B-2 module and overheard Davis talking to Flowers on his cell phone. Davis told Flowers the youth vomited, but was OK and sleeping. Davis then informed the officers in the B-2 module that Flowers said "call the nurse anyway."

- Incident Report by JJDO I Morris Drayton, dated July 18, 2011 - A review of this record showed that on July 10, 2011, at approximately 1:35 a.m., Drayton walked to his car to get a quarter for Davis, who was in the B-2 module. Drayton proceeded to the B-2 module and observed youth Perez asleep on the dayroom floor. Davis stated youth Perez was on the dayroom floor for observation because he was not feeling well. Drayton then returned to the B-4 module where Drayton was assigned. At approximately 2:15 a.m., Davis entered the B-4 module and stated he called the nurse, but there was no answer.

- Cell phone usage log for Superintendent Anthony Flowers - A review of this record showed Flowers received incoming calls from the Palm Beach RJDC on July 10, 2011, at 2:38 a.m. (lasting two minutes) and 3:07 a.m. (lasting six minutes).

- Video surveillance of the cafeteria for August 10, 2011 - A review of this record showed the following:

    - 7:41:00 p.m. (based on logbook entry due to video not having timestamps) – Lewis, Rios and Smith enter the cafeteria with 12 youths, including youth Perez (in beige jumper).

    - 7:41 p.m. – 7:53 p.m. (est.) – The youths are eating their snacks. Youth Perez is sitting at round blue table.

    - 7:53:01 – 7:53:13 p.m. (est.) - Smith frisk searches an unidentified youth, places his arms under the youth's arms, picks youth up, and drops him to his feet.

    - 7:53:15 p.m. (est.) - Rios begins frisk searching youth Perez.

    - 7:53:28 p.m. (est.) - Rios finishes frisk searching youth Perez. Smith gestures for youth Perez to approach him.

    - 7:53:34 p.m. (est.) - Smith begins frisk searching youth Perez and subsequently picks him up with both hands.

    - 7:53:40 p.m. (est.) - Smith drops youth Perez. Youth Perez falls toward a table and remains on his feet.

    - 7:53:49 p.m. (est.) - Rios pushes an unidentified youth toward Smith.

    - 7:54:15 – 7:54:23 p.m. (est.) - Smith uses both hands to pick up the same unidentified youth by his uniform, holds him above the floor in a horizontal position, and attempts to swing him back and forth. The youth is returned to his feet and he walks away.

    - 7:54:58 p.m. (est.) - An unidentified youth tosses a snack onto a table.

    - 7:55:01 p.m. (est.) - Youth Perez picks up snack off of table.

    - 7:55:03 – 7:55:14 p.m. (est.) - Rios frisk searches an unidentified youth, picks him up, drops him on his feet.

    - 7:55:17 – 7:55:28 p.m. (est.) - Rios pulls an unidentified youth toward him, conducts a search, picks up the youth and tosses him toward a wall. The youth remains on his feet.

- 7:55:32 p.m. (est.) - Youth Perez tosses snack back onto table.
- 7:55:54 p.m. (est.) - Smith begins frisk searching youth Perez for the second time.
- 7:56:04 – 7:56:13 p.m. (est.) - Rios assists Smith with lifting youth Perez into the air so that the youths' legs are higher than the youth's head.
- 7:56:13 p.m. (est.) - Youth Perez is dropped and he falls to the floor with his back against the wall.
- 7:56:18 p.m. (est.) - Youth Perez stands up.
- 7:56:00 p.m. (based on logbook entry) – Lewis, Rios, and Smith exit the cafeteria and return to B-2 module with 12 youths.

- Training documentation consisting of CORE account printouts - A review of these records covering July 2010 to July 2011 showed the following:
  - Rios received PAR certification on June 23, 2008, and completed most recent annual update on September 10, 2010. Rios completed "Promoting Professional & Appropriate Staff Conduct (Parts 1 & 2)" and "Safety and Searches" on February 8, 2011.
  - Smith received PAR certification on August 18, 2010. Smith completed "Promoting Professional & Appropriate Staff Conduct (Parts 1 & 2)" on August 11, 2010 and February 21, 2011, and completed "Safety and Searches" on March 12, 2011, (Attachment D-43).

- E-mail sent to Corizon Health, Inc. [formerly Prison Health Services Regional Manager] Tish Wright, dated July 11, 2011 - A review of this record showed Shore directed Wright to remove Clough from duty at the Palm Beach RJDC and other DJJ sites pending the outcome of the investigation.

- E-mail sent to OIG staff, dated March 14, 2012 - A review of this record showed Shore stated Clough did not return to the Palm Beach RJDC after she was removed from duty.

- Collected photographs of the Palm Beach RJDC Master Control room – Specific reference to these photographs will be made in continuance to this report.

- Presentment of the Palm Beach County Grand Jury, dated March 8, 2012 - A review of this record showed the Grand Jury analyzed evidence including applicable policies and procedures, statements from staff and youths, video surveillance, and reports completed by medical examiners and pathologists. The Grand Jury concluded that officers engaged in "improper staff contact with residents" by participating in horseplay with youth Perez and other youths in the cafeteria on July 9, 2011. The Grand Jury concluded the quality of care provided to youth Perez on July 10, 2011, was "fundamentally and woefully inadequate", due to deficient officer training and the lack of an informed medical opinion. The Grand Jury found no existing statute criminalizing the officers' actions or lack of action. The Grand Jury made four recommendations consisting of the following: (1) DJJ officers should be trained as extensively as sworn correctional officers; (2) DJJ policies and procedures should require that a youth complaining of a medical condition be immediately assessed by a medical professional; (3) DJJ should have a medical

professional on-site at all times, or require officers to call 9-1-1 for outside assistance if a medical professional is not available; and (4) The Legislature should enact a statute addressing the criminal neglect of anyone in the care or custody of DJJ.

- Palm Beach County Medical Examiner report for youth Perez - A review of this record showed the cause of youth Perez's death was determined to be an intracranial hemorrhage (hemorrhagic stroke) of unknown etiology.

As part of this investigation other documents and exhibits were developed by OIG personnel. These documents or exhibits are identified as follows:

- Diagram detailing the configuration of the B-2 module - The diagram shows the locations of the module sub-control room, youth rooms, bathroom/shower area, tables and chairs, surveillance cameras, and 9-1-1 posters.

- Still images generated from video surveillance footage of the B-2 module – Prepared to succinctly identify what the video surveillance showed. Photos # 1 and # 2 show youth Perez on the floor outside of his room. Photos # 3 and # 4 show youth Perez falling into a table and then to the floor. Photos # 5 through # 8 show youth Perez attempting to stand/walk, but falling to the floor. Photos # 9 through # 11 show youth Perez sitting up and vomiting as Powell and Davis stand approximately eight feet away. Photos # 12 through # 14 show Jarrell lifting youth Perez's mat and youth Perez falling to the side and partially onto the tile floor. Photos # 15 through # 18 shows Davis and Powell attempting to assist youth Perez to his feet and subsequently leaving him on the tile floor. Photo # 19 shows Davis tapping youth Perez's left arm. Photo # 20 shows Davis and Powell dragging youth Perez on the mat. Photos # 21 and # 22 show Davis and Powell attempting to assist youth Perez to his feet. Photo # 23 shows Davis and Powell dragging the mat youth Perez is laying on to the B-2 module exit.

- Still images generated from video surveillance footage of the cafeteria – Prepared to succinctly identify what the video surveillance showed. Photo # 1 shows Smith picking up an unidentified youth. Photos # 2 through # 6 shows Rios searching youth Perez and Smith subsequently picking him up and dropping him. Photos # 7 and # 8 show Rios pushing an unidentified youth toward Smith and Smith subsequently picking him up and holding him in a horizontal position above the floor. Photo # 9 shows Rios picking up an unidentified youth. Photo # 10 shows Rios picking up an unidentified youth and tossing him toward a wall. Photos # 11 through # 13 show Smith searching youth Perez and Rios assisting with lifting him into the air and dropping him to the floor. Photo # 14 shows youth Perez standing up prior to exiting the cafeteria.

As part of this investigation other documents and exhibits were developed by Detention Services personnel. These documents or exhibits are identified as follows:

- **Detention Services Response** – Prepared at the Direction of Assistant Secretary Julia Strange to document a timeline of events that took place in response to the death of youth Perez.

- **Corrective Action Plan (CAP)** – Developed to assess the policies, management practices and operations at the Palm Beach RJDC and provide accountability and assignment to the completion of actions to be taken.

III. INVESTIGATIVE NARRATIVE

The following interviews were conducted during this investigation. The interviews were sworn and digitally recorded unless otherwise noted. Below are notations from these interviews. All interviews were conducted by former Inspector Specialist Scheeley and Investigations Coordinator Michael unless otherwise noted.

(1) Anthony Flowers, Former Superintendent II
5488 Berry Blossom Way East,
West Palm Beach, Florida 33415
Location: Palm Beach RJDC
Date: July 11, 2011

- Flowers stated he was contacted by Supervisor Terrance Davis on July 10, 2011, at approximately 2:39 a.m. Flowers stated Davis told him youth Eric Perez awoke yelling, "Get him off of me," and staff had counseled the youth and calmed him down. Davis then said he removed youth Perez from his room and placed him on the dayroom floor where he later threw up. Flowers stated he told Davis to contact the nurse [Registered Nurse] and told Davis where to find her telephone number.

- Flowers stated at approximately 3:09 a.m., Davis called Flowers a second time and stated he was unable to reach the nurse and had left several voice mail messages for her. Davis went on to state youth Perez was "Ok" and was sleeping on the dayroom floor. Davis told Flowers staff would monitor the youth and Davis would advise Flowers of any changes.

- Flowers stated he concurred with Davis and did not hear anything further from Davis until Flowers arrived at the facility.

- Flowers stated Davis did not tell him the youth had been hallucinating or was incoherent.

- Flowers stated when Davis told him youth Perez had awaked yelling, "get him off me", Flowers assumed the youth had been dreaming and had a nightmare.

- Flowers stated he was not told youth Perez was unable to walk or sit up as evidenced by the surveillance footage. Flowers stated had he been given this information he would have instructed Davis to contact 9-1-1 immediately. Flowers stated staff should have called 9-1-1 when the youth was first brought out of his room and could not walk, Flowers further stated staff should have called 9-1-1 when the youth could not walk into the showers or confinement and had to be dragged on his mattress.

- Flowers acknowledged that the facility FOP requires the Designated Health Authority and not the nurse be contacted during off-duty hours. Flowers stated he was half-asleep when Davis called and he automatically told Davis to contact the nurse as this is typically who the program calls.

- Flowers stated staff have never been prohibited or discouraged from contacting 9-1-1 and this is re-emphasized during periodic trainings.

(2) Terence Davis, Former Juvenile Justice Detention Officer Supervisor
420 West 31st Street, West Palm Beach, FL 33404
Location: Palm Beach RJDC
Dates: July 10, 2011 and July 11, 2011

- Davis confirmed he was the assigned supervisor for "C" shift, (11:00 p.m. to 7:00 a.m.).
- Davis stated he assigned [Juvenile Justice Detention Officer II Floyd] Powell and JJDO I [Christian] Lewis to work the B-2 module.
- Davis explained that at approximately 1:25 a.m., Powell called him on the radio and requested his presence in the B-2 module due to a "serious issue."
- Davis entered the B-2 module and observed youth Perez in his room walking around and repeatedly yelling, "Get off of me! I can't hear!"
- Davis said Powell obtained youth Perez's file and he (Davis) reviewed it for pertinent medical information. Davis only found indicators of marijuana use and depression.
- Davis directed youth Perez's roommate (youth [James West]) be moved to another room to prevent additional issues.
- Davis stated he attempted to talk with youth Perez, who was initially unresponsive but subsequently answered basic "yes" or "no" questions.
- Davis stated he decided to remove youth Perez from the room, and youth Perez "stumbled out like he was intoxicated."
- Davis stated he continued attempting to process with youth Perez regarding what was wrong.
- Davis stated Perez proceeded to walk around the module and then sat down and expressed he "wanted the pain in his head to go away."
- Davis stated he assisted youth Perez to a mat on the dayroom floor, where he fell asleep and started to snore.
- Davis stated he exited the module, but was called back at approximately 2:30 a.m. when youth Perez vomited. Davis stated youth Perez "rolled over, tried to stand up, and made low moaning voices." Davis stated youth Perez vomited from his mouth and that the secretions from his nose resembled "snot bubbles." Davis described the vomit as appearing to be the same color as the door of youth Perez's room.
- Davis stated he attempted to stand youth Perez up and assist him to the bathroom for a shower, but youth Perez "didn't have enough strength because he had lost so much fluid."
- Davis stated Powell comprised the plan to "let him [youth Perez] sleep and then wake him up early for a shower."

- Davis stated Powell asked at one point "should we call 9-1-1" and denied Powell attempted to call and was prevented from doing so.

- Davis stated he was "open to anything" and would not have objected to calling 9-1-1, but was unsure at the time if it was necessary because youth Perez fell asleep; therefore, he opted to contact Superintendent [Anthony] Flowers instead.

- Davis stated his first telephone conversation with Flowers consisted of reporting youth Perez was unresponsive and "making noises," but became responsive and fell asleep after his placement on the dayroom floor.

- Davis stated Flowers directed him to call [Registered Nurse] [Diana] Heras and to update Flowers on any status changes.

- Davis stated he made two unsuccessful attempts to contact Heras and left voicemail messages. Davis was unsure if his voicemail messages referred to the situation as an emergency.

- Davis stated he notified Flowers a second time and reported he was unable to contact Heras and that youth Perez had vomited, but fell sleep and was snoring loudly.

- Davis stated he couldn't recall if he told Flowers during either conversation that youth Perez was unable to walk.

- Davis stated Flowers did not direct him to refrain from calling 9-1-1.

- Davis stated youth Perez remained on the dayroom floor until approximately 5:40 a.m. when he was moved to the medical confinement cell. Prior to moving youth Perez, Davis gave him a sip of Sprite soda to "stabilize his stomach."

- Davis stated youth Perez was dragged to the medical confinement cell while he lied on the mat because, "We didn't want to risk dropping or hurting him while assisting him."

- Davis stated youth Perez was awake, but "coming and going" and "mumbling" something Davis translated as meaning "wanting sleep."

- Davis stated he assigned JJDO I [Laryell] King to maintain constant supervision of youth Perez until approximately 6:45 a.m., when supervision reverted to 10-minute room checks.

- Davis explained he conducted several checks of youth Perez and noted he was snoring.

- Davis stated when the nurse [Licensed Practical Nurse Marcia Clough] arrived, he informed her that youth Perez was in medical confinement and needed to be seen, but was snoring.

- Davis stated at approximately 7:45 a.m., he noticed youth Perez was not snoring, prompting Davis to radio a "code white" (medical alert). The Automated External Defibrillator (AED) was brought to the cell and Emergency Medical Services (EMS) was notified. The AED alerted, "no shock needed" and Davis and JJDO II [Randolph] Roberts performed Cardiopulmonary Resuscitation (CPR) until EMS arrived. When EMS arrived, they could not revive youth Perez and he was pronounced dead.

After reviewing video coverage of the incident involving youth Perez and actions by staff, former Inspector Specialist Scheeley and Investigations Coordinator Michael re-interviewed Davis to determine why he did not render aid to youth Perez after he stumbled across the module and hit a table while falling to the floor.

- Davis stated he and Powell were assessing the situation and talking to youth Perez.
- Davis stated youth Perez "broke his fall and must have been coherent enough to do so."
- Davis acknowledged he knew something was wrong with youth Perez, but was trying to determine to what degree.
- Davis stated all of the verbalizations youth Perez was making in his room ceased and "everything changed" after he was brought into the dayroom.
- Davis stated anything was possible and there was a potential that youth Perez may be faking his condition.
- Davis denied he made any specific comments to other staff about youth Perez faking his condition.
- Davis stated he figured youth Perez wanted to sleep and "whatever was in his system he vomited it out"; therefore, he did not call 9-1-1. Davis stated he remained focused on "showering youth Perez and seeing what happens."
- Davis stated his goal was to "keep youth Perez comfortable until a nurse arrived."
- Davis emphatically denied he directed Powell not to call 9-1-1, despite witness statements indicating otherwise.
- Davis deferred to "interpretations" of what was being done and said at the time. Davis also claimed some staff may have an "axe to grind" against him. Davis confirmed he did not recognize the situation as life-threatening at the time, but acknowledged in hindsight he would have made different decisions, including calling 9-1-1.
- Davis denied being told there are potential repercussions for calling 9-1-1.

(3) Floyd Powell, Former Juvenile Justice Detention Officer II
5163 Glen Cove Lane, West Palm Beach, FL, 33415
Location: Palm Beach RJDC
Dates: July 10 and 11, 2011

- Powell stated he was assigned to the B-2 module with JJDO I [Christian] Lewis on the morning of the incident.
- Powell stated he was alone in the module and conducting 10-minute room checks at approximately 1:30 a.m. when he heard crying coming from room # 11.

- Powell stated he approached room # 11 and observed youth Perez walking around the room and crying.

- Powell stated he called for Davis by radio and he (Davis) responded to the B-2 module shortly afterward.

- Powell stated youth Perez came out of his room and he fell to the floor while still crying, unintelligibly. Powell said he and Davis attempted to help youth Perez to stand up, but were unsuccessful. Powell stated, "Every time youth Perez tried to get up, he would fall." Powell said he and Davis attempted to question youth Perez about what was wrong with him, but youth Perez "just kept crying out like something hurt."

- Powell stated he placed a mat on the dayroom floor at the direction of Davis. Powell stated he and Davis asked youth Perez to sit on the mat, and youth Perez did so, but he lost his balance and Powell and Davis caught him and laid him on the mat. Powell stated youth Perez became calm and stopped crying out, so Powell "didn't pay it any mind" and said, "he [youth Perez] probably don't like being in the room."

- Powell stated that at approximately 2:15 a.m., after Lewis and JJDO II [Marlon] Jarrell entered the module, youth Perez woke up and began to vomit on himself from his mouth and possibly his nose. Powell stated he did not observe any paint chips in the vomit. He said all three staff attempted to communicate with youth Perez and assist him up to clean him off, but were unsuccessful.

- Powell stated he radioed for Davis a second time, and after Davis responded to the module, Powell expressed to him the need to call 9-1-1.

- Powell stated Davis responded, "Hold on for a second."

- Powell stated he proceeded toward the module's sub-control room to call 9-1-1, but Davis responded, "No, no, do not call them yet. ... He [youth Perez] will be ok. ... It's not life threatening."

- Powell stated Davis called Superintendent [Anthony] Flowers first. Powell said Davis later told him he spoke with Flowers and was directed to call the nurse and not 9-1-1. Powell said by this time, youth Perez had fallen asleep and was snoring. Powell stated youth Perez "looked dead" prior to being moved to medical confinement, but Powell heard him still breathing and snoring.

- Powell stated at approximately 5:40 a.m., youth Perez was dragged to medical confinement while on his mat because he "was very weak and couldn't walk." Powell stated youth Perez mumbled unintelligibly as he was dragged.

On July 11, 2011, OIG staff re-interviewed Powell while viewing with him video surveillance related to the incident.

- Powell stated when youth Perez came out of room # 11, Davis directed youth Perez to stay on the floor as they attempted unsuccessfully to communicate with him.

- Powell stated he retrieved youth Perez's file from the sub-control room and handed it to Davis.

- Powell stated he and Davis continued to look through youth Perez's file as youth Perez remained on the floor in a kneeling/fetal position with his head down. Powell said youth Perez was not saying anything other than making moaning sounds.

- Powell stated youth Perez tried to stand up, but was unable to and remained on the floor. Powell was asked why neither he nor Davis ran to the aid of youth Perez after he eventually stood up, stumbled across the module, fell into the table, and struggled on the floor. Powell responded, "We were trying to look at his file and talking about what we needed to do." Powell added that youth Perez stopped crying out; therefore, Powell's intention was "to watch him for a little bit of time and see what was going to happen." Powell said youth Perez did not hit the table and instead "was trying to sit down at the table, but couldn't, so he just sat down on the floor."

- Powell stated he was then directed by Davis to retrieve youth Perez's mat from room # 11 so youth Perez could be placed on it.

- Powell said Davis' body language and demeanor gave the impression that the youth's condition "was no big deal" and "was not life threatening."

- Powell acknowledged that while he and Davis attempted to escort youth Perez to the bathroom after he vomited, youth Perez continued to show difficulty with standing, struggled on the floor, and failed to respond to numerous verbal prompts. Powell stated after staff attempted to escort the youth to the showers youth Perez was placed back on the mat and he eventually fell asleep, so Powell thought the youth was ok.

- Powell stated at approximately 5:20 a.m., he attempted to wake up youth Perez by tapping him and shaking his mat, but youth Perez made only low moaning sounds.

- Powell said Lewis had suggested to him that they shower youth Perez before waking up the other youth. Powell said when Davis returned to the module they (Powell and Davis) dragged youth Perez to the entrance of the bathroom, as he lied on the mat.

- Powell stated youth Perez was still unable to stand on his own so Davis directed youth Perez be moved to a medical confinement cell. Powell said Davis and Lewis dragged youth Perez to the medical confinement cell as he lied on his mat.

- Powell stated he approached Davis several times about needing and wanting to call 9-1-1, and reiterated he attempted to call after youth Perez woke up, started to vomit and was unable to stand on his own. Powell stated Davis told him "no" because the situation "was not life threatening" and he was going to call Flowers instead.

- Powell stated he ultimately accepted Davis' direction and assessment of youth Perez, and no further discussion of 9-1-1 occurred for the remainder of the time youth Perez was in the module, despite his on-going condition.

- Powell stated in regard to calling 9-1-1 "There would be no problem." Powell acknowledged during both interviews he could have notified Master Control by radio to call 9-1-1. Powell also acknowledged he received prior 9-1-1 training and was aware that all staff can contact 9-1-1 without a supervisor's permission.

(4) Christian Lewis, Former Juvenile Justice Detention Officer I
1453 40th Street, West Palm Beach, FL, 33407
Location: Palm Beach RJDC
Dates: July 10, 2011; July 15, 2011 and December 21, 2011

- Lewis stated he was assigned to the B-2 module with JJDO II [Floyd] Powell on the morning of the incident and was working a double shift.
- Lewis stated at approximately 1:40 a.m. on July 10, 2011, he was in Master Control relieving another staff when he heard a call on the radio asking for Davis to come over to the B-2 module.
- Lewis stated he could see on the surveillance camera that something was happening in the B-2 module, but was unable to determine exactly what it was.
- Lewis stated he returned to the B-2 module at approximately 2:15 a.m. and was advised by Davis that youth Perez had been "hallucinating" and was placed on the dayroom floor for the night so he could be monitored.
- Lewis stated approximately 15-20 minutes later, he observed youth Perez sit up and expel "beige" vomit from his mouth and nose. Lewis reported he observed a "rolled-up marble-sized ball" in the vomit.
- Lewis stated he proceeded to exit the module to locate Davis. When Davis and Lewis returned, Powell questioned Davis about needing to call 9-1-1, which he and Davis agreed it was appropriate.
- Lewis stated Powell proceeded to exit the module to call 9-1-1, but Davis stated to him to hold off calling until he contacted Superintendent [Anthony] Flowers first.
- Lewis stated after Davis made the call to Flowers, Davis informed he and Powell that Flowers said not to call 9-1-1 and to instead call the nurse for direction.
- Lewis stated he verbally prompted youth Perez several times, but youth Perez just "kept moving" and did not provide a verbal response. Lewis believed that youth Perez was "ok" after he vomited and was only trying to get comfortable on the mat. Perez then began snoring, which Lewis interpreted as him sleeping.
- Lewis stated he later talked to Davis about the possibility that youth Perez had swallowed something such as paint. Lewis and Davis examined youth Perez's room and noticed paint had been scraped and peeled off the mirror and backside of the door.
- Lewis stated between 5:00 a.m. and 5:20 a.m., he, Powell, and Davis attempted to wake youth Perez, but he was unresponsive, kept snoring, and was like "dead weight."
- Lewis stated while youth Perez was lying on his mat on the floor, he observed Davis and Powell attempt to assist youth Perez up but they were unsuccessful. At approximately 5:40 a.m., when unable to wake youth Perez, Davis and Lewis dragged youth Perez to the medical confinement cell as he lay on his mat.

- Lewis stated no further discussion or mention of 9-1-1 took place and he mainly relied on Davis' decision-making.

- Lewis stated he checked youth Perez at approximately 7:00 a.m. before leaving the facility. Lewis stated he could hear Perez snoring through the door of the medical confinement cell.

On July 15, 2011, Investigations Coordinator Michael and former Inspector Specialist Scheeley re-interviewed Lewis while viewing with him video surveillance related to the incident.

- Lewis stated when he returned to the B-2 module (on July 10, 2011) after working in Master Control, he had no knowledge of what was happening with youth Perez other than being told Perez was "hearing things in his sleep."

- Lewis stated he exited the module to locate Davis while youth Perez vomited.

- Lewis stated once Davis was on the scene and addressing the situation, he did not question him about youth Perez or his condition, including why he was left to lie on the bare floor.

- Lewis reiterated him, Powell, and JJDO I [Laryell] King did agree amongst them at one point that 9-1-1 needed to be called, but Davis later responded "no" to the suggestion and preferred to call Flowers first.

- Lewis stated he encountered Davis in the supervisor's office toward the end of the call (with Flowers) and Davis' impression was that the situation was not an emergency.

- Lewis observed Davis in the module using his cell phone to contact Flowers a second time, but could not recall the content of the conversation.

- Lewis stated he and Davis considered youth Perez as being "ok" once he vomited, settled onto his mat, and fell asleep.

- Lewis stated Davis had made comments alluding to youth Perez "faking" because he was friends with and in the same gang as another youth who allegedly faked an illness as an attempt to get out of the module and the facility.

Lewis was questioned why he walked away from youth Perez after multiple failed attempts to wake him up prior to dragging him to the medical confinement cell.

- Lewis stated "I thought he was asleep because he was snoring" and "we just wanted to shower him."

- Lewis stated he proceeded with the morning routine and at one point "really wasn't paying attention" because Davis was with youth Perez.

- Lewis stated the idea to drag youth Perez on the mat was Davis' and this is not a normal procedure.

- Lewis described the entire situation as "confusing," and added, "You want to do something, but you feel like if you do it, you will get in trouble because you were already told not to do it."

- Lewis stated he only did what Davis directed him to do and was working off information he provided.

- Lewis stated "I really don't know; maybe, maybe not" when was asked if there would have been repercussions or consequences for taking control of the situation himself and calling 9-1-1 despite Davis' directives.

- Lewis admitted in hindsight the situation should not have progressed as long as it did and 9-1-1 should have been contacted when first mentioned.

- Lewis stated he received prior 9-1-1 training and was aware any staff can call at any time.

(5) Laryell King, Former Juvenile Justice Detention Officer I
10359 Showboat Lane, Royal Palm Beach, FL, 33411
Location: Palm Beach RJDC
Dates: July 10, 2011

- King explained she was assigned to the B-4 module on the morning of the incident.

- King recalled hearing a code or "some type of radio transmission" coming from the B-2 module. King responded to the B-2 module and observed youth Perez leaning to the side on a mat on the dayroom floor.

- Youth Perez had already vomited a "pinkish orange" substance.

- King denied seeing anything resembling paint chips in the vomit.

- King described youth Perez as quiet, lethargic, and looking "doped up." King assisted with cleaning up the vomit and then exited the module.
- King returned to the module approximately two hours later and observed youth Perez "still lying down." King stated she attempted to communicate with youth Perez by calling his name, but he was unresponsive and snoring.

- King stated Davis and another unidentified staff subsequently tried to assist youth Perez up to shower him, but he was "too lethargic" and still looked "doped up."

- King stated she later provided constant supervision of youth Perez for approximately 45 minutes after he was moved to the medical confinement cell.

- King stated Davis reverted the supervision of youth Perez to 10 minute room checks, which King completed two before returning to the B-4 module.

- King stated during his supervision and subsequent room checks of youth Perez, she heard him make no sounds other than "snoring."

- King stated when she was in the B-2 module the first time, she heard JJDO II [Floyd] Powell questioning Davis about calling 9-1-1, but she could not recall the exact verbiage. King stated Davis responded he was going to call the Superintendent [Anthony Flowers].

- King reported Davis returned to the module and stated he was told by Flowers to "hold off" calling 9-1-1 and instead to call the nurse.

- King stated she talked to Powell afterward about calling 9-1-1 and Powell offered mixed feelings about what to do. King acknowledged that either she or Powell could have called 9-1-1 without any repercussions, but Davis was soliciting feedback and trying to determine what steps to take.

- King stated she did not have a full picture of what had happened with youth Perez earlier, and based on the information she received at the time, she did not see the situation as necessitating a 9-1-1 call.

On July 15, 2011, Investigations Coordinator Michael and former Inspector Specialist Scheeley re-interviewed (sworn, recorded) King while viewing with her video surveillance related to the incident. King was questioned about why youth Perez was left to lie on the bare floor for an extended amount of time and why she did not take action to get him help.

- King stated she had considered the situation as simply involving a youth who was really sick, and that it was under control by the officers who were in the module longer than herself and had more information. As a result, King waited to see what decisions they were going to make.

- King admitted she eventually became concerned about youth Perez's condition when he presented an unresponsive to her verbal prompts, but again considered Davis as being in the lead and determining the plan of action.

- In regard to repercussions if she took charge of the situation and decided to call 9-1-1 on her own, she responded, "Honestly, I don't know because the supervisor [Davis] was giving directives and he said that the Superintendent [Flowers] told him we are not supposed to call."

- King stated at some point she and other staff questioned amongst themselves the decisions of their superiors, but they did not have enough information to determine one way or another if what was being done was in the best interest of youth Perez.

- King stated in hindsight, the situation was not under control and admitted she could have made better choices, but added that at the time there was a sense of fear and apprehension about overstepping authority and taking action such as calling 9-1-1.

- King acknowledged she received prior 9-1-1 training and expressed awareness that any staff may call at any time.

(6) Marlon Jarrell, Former Juvenile Justice Detention Officer II
1829 SW Citadel Avenue, Port St. Lucie, FL, 34953
Location: Palm Beach RJDC
Date: July 11, 2011

- Jarrell stated he has been employed at the Palm Beach RJDC for approximately three and one half years.

- Jarrell stated he was assigned to the B-1 module with JJDO I [Lydia] Sanchez on the morning of the incident.

- Jarrell stated he heard JJDO II [Floyd] Powell radio for Davis to report to the B-2 module "immediately." Jarrell confirmed he responded to the B-2 module after Sanchez returned from a break.

- Jarrell stated upon entering the B-2 module, he was informed by Powell that youth Perez was placed on the dayroom floor because he was making noises in his room and "hallucinating."

- Jarrell stated JJDO I [Christian] Lewis entered the B-2 module shortly afterward, and as all three officers spoke with each other, Jarrell observed youth Perez sit up and start to vomit from his mouth and nose. Jarrell identified the vomit as a "white and pinkish" liquid with a sweet smell.

- Jarrell reported he heard Powell state to Davis that they should call 9-1-1, but Davis did not respond.

- Jarrell stated he observed Davis and Powell attempt to escort youth Perez to the bathroom, but youth Perez was limp, unable to stand on his own, and presented as if "he didn't know where he was at."

- Jarrell stated he heard Powell say he was going to call 9-1-1, but Davis told him "no" due to the situation "not being a life threatening emergency."

- Jarrell stated he then suggested to Davis that he call Superintendent Flowers.

- Jarrell stated he later spoke with Davis in Master Control and Davis told him that Flowers said to call the nurse. At the same time, Jarrell stated he overheard Davis talking to JJDO I [Ronald] Paul (who was assigned to Master Control) and state that he thought youth Perez was "faking" his illness and "some women want to be pregnant and think they are pregnant, so they force themselves to vomit."

On July 15, 2011, Jarrell was re-interviewed (sworn, recorded) following his review of the video surveillance related to the incident. Jarrell was questioned as to why youth Perez was left to lie on the bare floor.

- Jarrell stated he lifted youth Perez's mat to prevent him from choking while he was vomiting and this caused youth Perez to fall to the side.

- Jarrell acknowledged that youth Perez was left on the bare floor, but he provided no explanation other than his belief that youth Perez was still vomiting.

- Jarrell stated he approached youth Perez and attempted to communicate with him, but youth Perez "just looked up at me and didn't say anything."

- Jarrell stated he observed Davis and Powell subsequently attempt several times to assist youth Perez from the floor and escort him to the bathroom, but youth Perez fell back to the floor and was unable to walk on his own.

- Jarrell returned to the B-2 module and noticed youth Perez was still on the bare floor, so he re-positioned him on the mat.

- Jarrell stated he assisted with cleaning up the vomit, exited the B-2 module, and did not return for the remainder of the shift.

- Jarrell stated no further discussion of 9-1-1 took place prior to him exiting the module for the final time.

- Jarrell "believed" he previously attended 9-1-1 training, but claimed calling 9-1-1 "is up to the supervisor." Jarrell claimed he was unsure of the 9-1-1 policy and that signs are not posted in the modules.

- Jarrell acknowledged in hindsight during both interviews that 9-1-1 should have been called due to youth Perez's condition; however, at the time of the incident he deferred to the direction and judgment of Davis.

(7) Mismaille Souffrant, Juvenile Justice Detention Officer I
8185 Belvedere Road, Apartment 107, West Palm Beach, Florida, 33411
Date: July 22, 2011
Location: Palm Beach RJDC

- Souffrant stated she has been employed at the Palm Beach RJDC for approximately four years and 11 months.

- Souffrant stated she heard a radio call for supervisor assistance coming from the B-2 module.

- Souffrant walked to the B-2 module, she encountered Lewis in the hallway. Souffrant questioned Lewis about what was going on and Lewis responded that a youth "was hearing voices" and subsequently was placed on the dayroom floor.

- Souffrant stated during the conversation with Lewis, Davis arrived and told Lewis that youth Perez was "faking" and "wanting to go to Columbia [Hospital] to escape because his parents didn't want him." Davis proceeded to demonstrate how youth Perez was "faking." Davis performed body motions and referenced youth Perez falling into the table. Souffrant added she heard Davis state he was not going to take youth Perez to Columbia Hospital because he "did not want to complete a CCC report."

- Souffrant stated she later walked to the B-2 module, but only stood in the doorway. During this time, Souffrant heard a telephone conversation between Davis and Flowers. Davis stated to Flowers that youth Perez had vomited, but was "ok and sleeping." Davis provided no other details and stated that Flowers directed him to call the nurse.

- Souffrant stated she never actually saw youth Perez during the entire shift and wasn't fully aware of the situation.

(8) Lydia Sanchez, Juvenile Justice Detention Officer I
4424 Rachael Way, West Palm Beach, Florida, 33406
Date: July 22, 2011
Location: Palm Beach RJDC

- Sanchez stated she has been employed at the Palm Beach RJDC for approximately three years and seven months.
- Sanchez stated she was assigned to the B-1 module with Jarrell on the morning of the incident.
- Sanchez stated that early in the shift, she heard a radio call requesting Davis to report the B-2 module.
- Sanchez stated that as the shift progressed, Davis entered the B-1 module about four or five times and made comments about youth Perez.
- Sanchez stated Davis first said "a kid was acting up" in the B-2 module, "seeing things" and "saying somebody was on him." During subsequent stops in the B-1 module, Davis said that youth Perez had vomited, "seemed lost" and "may be high from eating paint." Davis also expressed his belief that youth Perez was "trying to go to Columbia [Hospital] so he could escape" because another youth known to youth Perez did the same thing.
- Sanchez stated Davis mentioned Flowers was aware of the situation and had directed him to keep the youth on the dayroom floor and continue to monitor him.
- Sanchez observed that Davis did not appear concerned and was not treating the situation as an emergency; therefore, she figured Davis was in control of the matter.
- Sanchez stated Jarrell left the B-1 module for what she initially thought was his break. When Jarrell returned, he only referred to youth Perez vomiting, but provided no further details.
- Sanchez stated she did not enter the B-2 module during the entire shift and at the time was not aware of the youth, his name, or the full nature of the situation.

(9) Ronald Paul, Juvenile Justice Detention Officer I
4940 Haverhill Commons Circle, Apartment 27, West Palm Beach, Florida, 33417
Location: Palm Beach RJDC
Date: July 12, 2011

- Paul stated he was assigned to Master Control during "C" shift (11:00 p.m. – 7:00 a.m.).
- Paul stated between 2:00 a.m. and 2:15 a.m., he noticed more officers than usual were present in the B-2 module.
- Paul stated he called to the module through the intercom system and asked what was wrong, but nobody responded to him.
- Paul stated he heard unidentified staff talking amongst themselves and debating about calling 9-1-1, and he heard Davis respond that he needed to call the superintendent.

- Paul stated Davis later entered Master Control and said a youth [youth Perez] was sick and throwing up.

- Paul stated Davis attempted to contact the nurse [Diana Heras] by telephone, but was unsuccessful and left a message indicating a youth [youth Perez] was sick and needed assistance.

- Paul stated Davis came back to Master Control and attempted to contact Heras a second time, but was unsuccessful and left a similar message asking Heras to call back as soon as possible.

- Paul stated he was directed by Davis afterward to try and contact Heras; however, Paul was unsuccessful and left a message referring to an "urgent situation."

- Paul stated during one of Davis' calls to the nurse, Jarrell was near the Master Control door. Paul stated he heard Davis talking to Jarrell about youth Perez's symptoms, and Davis subsequently made a comment referencing "women who can fake pregnancy and make themselves vomit."

- Paul stated Davis did not mention calling 9-1-1.

- Paul stated Davis expressed he made an "assessment" of youth Perez's condition based on observations of symptoms, and Davis was confident with the assessment and felt calling the nurse was the best thing to do.

- Paul stated no other staff spoke with him about youth Perez and he did not have any additional direct knowledge of the incident.

On March 16, 2012, a follow-up interview of Paul was conducted at the Palm Beach RJDC by Investigations Coordinator Michael and Inspector Specialist Scheeley.

- Paul stated his primary assignment during Charlie shift was Master Control and he did not work in any other area.

- Paul stated the Master Control operator is "the eyes of the facility." Paul stated the Master Control operator manages the logbook, takes phone calls, listens to radio transmissions, monitors the video surveillance screens, conducts facility counts, completes paperwork on the computer, and completes other tasks directed by the shift supervisor. Paul stated Master Control has six video surveillance screens.

- Paul stated the cameras do not capture audio and hearing audio from a specific location requires using the intercom system.

- Paul stated Alpha shift (7:00 a.m. to 3:00 p.m.) and Bravo shift (3:00 p.m. to 11:00 p.m.) are busier than Charlie shift, but this does not mean it is possible to watch the surveillance screens non-stop without interruption or needing to complete other tasks.

- Paul stated between approximately 1:00 a.m. and 2:00 a.m., he went to his car for a break. Paul stated he did not remember who relieved him, but when shown a logbook entry completed by [JJDO I Christian] Lewis, Paul concurred [Lewis had been his relief].

- Paul stated upon returning to Master Control, Lewis did not provide any information referencing an issue in the B-2 module.

- Paul stated he first became aware of activity in the B-2 module when he observed Davis, Jarrell, [JJDO I Laryell] King, and [JJDO II Floyd] Powell standing near a youth, but Paul could not tell what they were doing. Paul stated the youth was lying on a mat on the floor, but it is not unusual, especially if a youth is on precautionary observation (suicide watch) or being non-compliant.

- Paul stated he thought the youth was acting up and not wanting to move to where staff was directing him to move to. Paul stated he called over to the module on the intercom system to gather information, but nobody responded to him.

- Paul stated he heard the staff talking, but the conversation was muffled. Paul stated he did not hear a specific staff express wanting to call 9-1-1 and he was not approached by any staff during the shift about wanting to call 9-1-1.

- Paul could not recall making the statement in his first interview concerning staff debating calling 9-1-1.

- Paul stated the conflicting statements were due to being "confused" and to hearing an increased amount of talk about 9-1-1 on the days immediately following the incident.

- Paul stated at one point he observed what appeared to be unidentified staff trying to move a youth to the bathroom, but the view on the screen made it difficult to clearly make out exactly what was taking place. Paul stated the cameras have zoom capabilities, but at the time he did not know how to do this and he did not want to mess up the settings.

- Paul stated Davis later entered Master Control and indicated Flowers told him to call the nurse because a youth was sick. Paul stated Davis made the situation look like "a normal thing" and did not appear alarmed or panicked.

- Paul stated Davis called the nurse two times and left messages in a calm tone of voice. Paul stated Davis' messages consisted of asking the nurse to call back whenever she could. Paul stated he also called the nurse but did not reach her.

- Paul stated he heard Jarrell talking to Davis near Master Control and Davis made the comment about women faking pregnancy and making them vomit.

- Paul stated he observed King cleaning the floor in the module, and per a comment made by Jarrell, this was because the youth had defecated on him.

- Paul stated this was not unusual to him because he experienced other youth's exhibit similar behavior as a form of defiance.

- Paul stated he possibly made a comment about notifying a qualified individual to assess the youth, but added the comment was based on the limited information he had at the time.

- Paul stated Davis had more firsthand knowledge of the situation and was in the position to determine the necessary plan of action.

- Paul stated the last he knew of the youth was that he had been moved to a confinement room.
- Paul stated he did not identify any signs of an emergency because he did not have all the details, he was not in the module to observe the youth, and whatever was happening, and the other staff appeared to be handling it.
- Paul stated it was difficult for him to judge the actions of the staff from where he was located because the information was fragmented and the staff did not provide him any solid feedback.

(10) Marcia Clough, Licensed Practical Nurse
440 W. 33rd Street, Rivera Beach, Florida
Location: Palm Beach RJDC
Date: July 10, 2011

- Clough stated she has been a LPN for approximately three years.
- Clough stated she arrived at the facility at 7:15 am on July 10, 2011, and printed out her sick call requests and checked to see if any youth were in medical confinement.
- Clough stated she did not see youth Perez's name on the medical confinement list.
- Clough stated she first became aware of a problem with youth Perez when she was walking in the hallway at the facility on July 10, 2011, at approximately 7:45 am.
- Clough stated an unidentified staff person approached her in the hallway and asked if she knew about the youth in medical confinement.
- Clough stated as she walked toward confinement, Davis approached her and said there was a youth in medical confinement who had been acting "bizarre" and threw up two to three times during the previous night. Davis described the vomit as being "pink tinged" and had "specs of paint" presumably from the youth's cell wall. Davis went on to state the youth was "galloping" around and that staff calmed the youth down and the youth then threw up but the youth was now sleeping in confinement.
- Clough stated she approached the area of medical confinement and the B-2 module when the unidentified officer looked in the confinement cell and stated the youth was still sleeping.
- Clough stated she heard "snoring noises" coming from the confinement cell and opted to do her rounds distributing medications and performing sick call before returning to see youth Perez.
- Clough stated she was in another module when she heard a "code" being called over the facility's intercom system. Clough stated she did not hear what type of code it was and that she does not carry a facility radio.
- Clough stated a short time later, an unidentified female staff approached her and said Clough was needed in confinement. Clough immediately stopped and locked up her medication cart and ran down to confinement.

- Clough estimated it took her approximately 15 seconds from the time she was notified by the female staff until her arrival in confinement.

- Clough stated as she arrived in confinement, two officers were performing CPR and the AED machine was on the youth. Clough stated the AED machine signaled it was analyzing the youth and all staff stepped away. The machine then read "no shock advised" and staff continued with CPR until the EMS arrived and assumed care of the youth.

(11) Randolph Roberts, Juvenile Justice Detention Officer II
4001 SW Kamsler Street, Port St. Lucie, Florida, 34953
Location: Palm Beach RJDC
Date: July 10, 2011

- Roberts has been employed at the Palm Beach RJDC for approximately four years.

- Roberts confirmed he was an EMT (Emergency Medical Technician) for approximately 23 years.

- Roberts stated after he reported for duty on the "A" shift, he assumed the 10 minute checks of youth Perez in the medical confinement cell at approximately 7:14 a.m.

- Roberts stated he did not know why youth Perez was in medical confinement until he spoke to the nurse Clough at approximately 7:30 a.m. At that time, Roberts learned Perez "was sick and vomited overnight, was a little incoherent, and seemed to be hallucinating, but later went to sleep after being placed in the medical confinement cell."

- Roberts stated he conducted visual checks of youth Perez until approximately 7:40 a.m. before proceeding to his assigned duty post.

- Roberts stated he observed youth Perez through the cell door and he was sleeping each time, as evidenced by snoring and a rising chest.

- Roberts stated shortly afterward, Roberts heard a "code white" [medical alert] called by Davis and responded to the medical confinement cell. Roberts assessed youth Perez and determined he was unresponsive with a "thready" pulse. Roberts called for the AED (Automated External Defibrillator) to be brought to the cell and for EMS (Emergency Medical Services) to be notified.

- Roberts stated after the AED was connected to youth Perez, it alerted, "no shock advised," indicating the presence of a pulse; however, Roberts could not locate a pulse.

- Roberts stated youth Perez continued to be unresponsive. The AED alerted, "No shock advised" a second time and Roberts and Davis continued with CPR until the nurse [Clough] and EMS arrived.

- Roberts stated he did not see any evidence of youth Perez having ingested paint chips; however, he observed red-tinged mucous discharge from youth Perez's mouth during CPR, which is a sign of aspiration.

- Roberts stated on-going medical conditions such as being incoherent, unresponsive, inability to walk; vomiting, and hallucinating should be a concern to anybody, regardless of their level of medical training.

- Roberts identified himself as the facility's training officer and confirmed he informs all staff in trainings that anyone can call 9-1-1 without needing supervisor approval and without fear of repercussions.

(12) Morris Drayton, Juvenile Justice Detention Officer I
411 Executive Center Drive, Apartment 214, West Palm Beach, FL, 33401
Location: Palm Beach RJDC
Date: July 22, 2011

- Drayton stated that during "C" shift [11:00 p.m. – 7:00 a.m.] on July 10, 2011, he was assigned to the B-4 Module with [JJDO I Laryell] King.

- Drayton stated between 1:00 and 1:30 a.m., he was on a break with Davis when Davis asked him for a quarter. Drayton stated he retrieved the quarter from his car and returned to the break room, but Davis was not there.

- Drayton stated he called Davis on the radio and Davis responded that he was in the B-2 Module.

- Drayton stated he entered the B-2 Module to give Davis the quarter and observed that youth Perez appeared to be sleeping on the floor.

- Drayton stated Davis was reading youth Perez's file and expressed youth Perez wasn't feeling well.

- Drayton stated he exited the module and did not see youth Perez for the remainder of the shift.

- Drayton stated Davis later entered the B-4 Module and stated he contacted Superintendent Flowers about youth Perez and was told to call the nurse, but Davis did not go into detail about the call or youth Perez's condition.

- Drayton stated he did not hear Davis make any comments alluding to youth Perez "faking" his condition, but Davis' body language and demeanor gave the impression that youth Perez would be "OK."

- Drayton stated he did not think the situation was serious at the time, because Davis did not say nor do anything that made it appear unusual or out of the ordinary.

- Drayton stated King did not say anything about youth Perez other than needing to supervise him in the confinement room later that morning.

- Drayton stated he worked in the B-2 Module the day before and observed youth Perez was happy and joking with other youths.

(13) Darrell Smith, Former Juvenile Justice Detention Officer I
1923 Abbey Road, Apartment 711, West Palm Beach, FL, 33415
Date: December 22, 2011
Location: Palm Beach RJDC

On December 22, 2011, OIG staff of record viewed with Smith video surveillance related to the allegations concerning the searching of youth within the cafeteria.

- Smith identified himself, Rios, and possibly Lewis as being present in the cafeteria during the time frame in question.
- Smith stated that at the onset of conducting searches of the youths, he engaged in "horseplay" with an unidentified youth by picking him up and dropping him to his feet.
- Smith stated he searched youth Perez after Rios had already done so because some youth were saying youth Perez was trying to sneak snacks back to the module.
- Smith stated his picking up youth Perez and dropping him on his feet was an act of horseplay.
- Smith stated his picking up an unidentified youth by his uniform and swinging him perpendicular to the floor was also an act of horseplay.
- Smith stated Rios also engaged in horseplay with other unidentified youths.
- Smith stated that while he searched youth Perez for a second time, he and Rios engaged in horseplay with youth Perez by lifting him into the air and dropping him to his feet.
- Smith admitted he shouldn't have been engaging in horseplay and attributed his conduct to a "low count" (number of youths).
- Smith stated he wasn't trying to hurt anybody, but admitted his actions were neither safe nor justified.
- Smith stated he knew engaging in horseplay can lead to more serious issues.
- Smith stated the main responsibilities of a JJDO are ensuring the safety and security of the youths.
- Smith stated he knew engaging in horseplay with the youths is prohibited by policy.
- Smith stated the searches were not done according to protocol or "by the book."

NOTE: All persons identified in this OIG report as SUBJECTS were advised of the allegations against them prior to and during the interview process. Additionally, all SUBJECTS were provided a second opportunity to respond to the OIG findings prior to the agency's recommended discipline/action.

The following interview was conducted during this investigation. This interview was sworn and digitally recorded. This interview was conducted by Keith W. Morris, Chief of Investigations.

(14) Julia Strange, Assistant Secretary
Department of Juvenile Justice
11 Meadowlark Drive, Crawfordville, FL 32327
Date: August 15, 2012
Location: DJJ Headquarters, Tallahassee, FL

- Strange stated following the death of youth Perez, an assessment of Palm Beach RJDC policies, management practices and operations was conducted by a team of DJJ staff beginning on September 11, 2011.

- Strange stated based on this assessment a Corrective Action Plan (CAP) was developed.

- Strange stated the CAP is broken down into several areas and to date continues to be followed and issues found not in compliance or in need of action are being taken.

- Strange stated at the request of the Secretary, Detention Services implemented assessments of new staff. The assessments are conducted through a program called Ergometrics System that is designed to screen potential candidates for employment in direct care positions in the juvenile justice system.

- Strange stated in regard to the Palm Beach Grand Jury Report recommendations – as the recommendations pertain to equivalent training among Detention staff as compared with state certified officers, her staff's assessment is that with the exception of a few topics, i.e., firearms training, the training is equivalent. As the recommendation pertains to Policies and procedures for the DJJ officers should require that any youth complaining of a medical condition should be immediately seen by a medical professional to evaluate whether emergency services are necessary; Strange said policies were in place and were not followed in this matter. As pertains to recommendation that DJJ must have a medical professional on site at the juvenile detention center at all times to evaluate any youth complaining of medical difficulties if there is no medical professional available to the child, the officers should be required to call 911 for outside medical assistance; Strange said budgetary restraint currently prohibit us (DJJ) from being able to provide twenty-four hour medical care; however, policy is in place that requires 9-1-1 to be called for outside medical assistance.

- Strange stated she will continue to reiterate, train and re-emphasize DJJ policies concerning the care of youth.

- Strange stated since this incident numerous staff were terminated at the Palm Beach RJDC and a new Superintendent and Assistant Superintendent have been assigned.

NOTE: Copies of the above referenced digitally recorded interviews are being maintained in the electronic case file for further review if necessary.

IV. CONCLUSIONS/RECOMMENDATIONS

1. **Violation of Policy/Rule and is covered by Palm Beach RJDC FOP # 4.10, Episodic and Emergency Care.**

During this investigation, testimony was received and documents were reviewed related to **Superintendent II Anthony Flowers'** failure to direct Juvenile Justice Detention Officer Supervisor Terence Davis to notify the Designated Health Authority for further direction regarding youth Perez's medical condition. From this activity, the following facts were established:

- Davis stated he first called Flowers to inform him youth Perez was unresponsive and "making noises," but became responsive and fell asleep on the dayroom floor." Davis stated Flowers directed him to contact the nurse (Registered Nurse Diana Heras) and to call Flowers back with any updates. Davis stated he called Flowers a second time to report he was unable to reach Heras[3] and that youth Perez had vomited, but was sleeping and snoring loudly. Davis stated he was unsure if he told Flowers that youth Perez was unable to walk.[4]

- Souffrant stated she was at the doorway of the B-2 Module and heard a telephone conversation between Davis and Flowers.[5] The staff stated Davis told Flowers that youth Perez had vomited, but was "ok and sleeping."

- Flowers stated Davis contacted him twice by telephone and informed him of youth Perez's condition.[6] Flowers stated Davis first reported that youth Perez woke up yelling "get him off of me" and later vomited. Flowers stated he directed Davis to call the nurse (Heras) for further instruction. Flowers stated that during the second call, Davis reported he was unable to reach Heras, but youth Perez was "ok" and sleeping on the dayroom floor.[7] Flowers stated he did not hear anything further from Davis until arriving at the facility later that morning. Flowers stated Davis did not tell him during either call that youth Perez was hallucinating, incoherent, and unable to walk or sit up, but if he had been made aware of this, he would have directed Davis to call 9-1-1. Flowers stated he knew the policy requiring notification of the Designated Health Authority during non-staffed clinic hours, but stated he was half asleep when Davis called and Flowers automatically directed Davis to call the nurse because this is who they typically call.

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Flowers** failed to direct Davis to notify the Designated Health Authority for further direction regarding youth Perez's medical condition. Therefore, a finding of **SUSTAINED** is recommended in this matter.

[3] Exhibit 25
[4] Exhibit 29
[5] Exhibit 32
[6] Exhibit 34
[7] Exhibit 18

2. **Violation of Policy/Rule and is covered by DJJ Health Services Manual (Revised 2010), Chapter 6, Sick Call.**

During this investigation, testimony was received and documents were reviewed related to **Licensed Practical Nurse Marcia Clough's** failure to thoroughly assess youth Perez's medical condition upon arriving at the facility for her assigned shift. From this activity, the following facts were established:

- Review of the confinement report for Perez, showed youth Perez was placed in medical confinement at 5:40 a.m. due to "vomiting all morning and not feeling well."[8]

- Davis stated when Clough arrived, Davis informed her of what happened with youth Perez and that he was in medical confinement and needed to be seen, but was snoring.[9]

- Clough stated she first became aware of a problem with youth Perez at approximately 7:45 a.m. while walking in the hallway of the facility.[10] Clough stated she arrived at the facility at 7:15 a.m. and printed out her sick call requests and checked to see if any youth were in medical confinement. Clough stated she did not see youth Perez's name on the medical confinement list, so she proceeded to distribute medication and assess other youths on sick call. Clough stated an unidentified staff approached her in the hallway and asked if she knew about the youth in medical confinement. Clough stated as she was walking toward confinement, Davis approached her and said there was a youth in medical confinement who had been acting "bizarre" and threw up two to three times during the night. Clough stated Davis described the vomit as pink tinged with specs of paint, presumably from the wall of the youth's room in the module. Clough stated Davis further stated the youth was "galloping" around and that staff calmed the youth down, and the youth then threw up, but was now sleeping. Clough stated she approached the area of medical confinement and the B-2 module when the unidentified staff looked in the confinement room and stated the youth was still sleeping. Clough stated she heard snoring noises coming from the confinement room and opted to proceed with distributing medications and performing sick call before returning to see youth Perez. Clough stated she was in another module when she heard a "code" called over the facility's intercom.

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Clough** failed to thoroughly assess youth Perez's medical condition upon arriving at facility for her assigned shift. Therefore, a finding of **SUSTAINED** is recommended in this matter.

3. **Violation of Policy and Improper Conduct, and is covered by Palm Beach RJDC FOP # 0.018, Facility Standards of Ethical Behavior; and Palm Beach RJDC FOP # 5.01, Supervision of Youth.**

During this investigation, testimony was received and documents were reviewed related to **Juvenile Justice Detention Officer I Alberto Rios** and **Juvenile Justice Detention Officer I Darrell Smith** engaging in improper searches and horseplay with youth Perez and four other unidentified youths. From this activity, the following facts were established:

[8] Exhibit 12
[9] Exhibit 17
[10] Exhibit 62

- Review of training records for the identified subject staff, showed each was certified in Protective Action Response, which trains staff in the proper use of physical intervention and how to conduct a person search. Staff also completed "Promoting Professional & Appropriate Staff Conduct (Parts 1 & 2)" and "Safety and Searches," which inform staff that engaging in horseplay is prohibited.[11]

- Review of video surveillance of the cafeteria, showed Rios and Smith engaged in activity that could be described as horseplay while conducting searches of youth Perez and four other unidentified youths.[12] Surveillance footage shows Smith lifted an unidentified youth off his feet and dropped him on his feet. Smith lifted youth Perez off his feet and dropped him on his feet toward a table. Rios pushed a second unidentified youth toward Smith, who subsequently lifted the youth off his feet and held him by his jumper as he swung him perpendicular to the floor before returning him to his feet. Rios lifted a third unidentified youth off his feet then dropped him on his feet. Rios lifted a fourth unidentified youth off his feet and tossed him on his feet toward a wall. Rios and Smith lifted youth Perez off his feet, raised his feet above his head, and dropped him on his feet. Youth Perez appeared to fall backward and hit his head against the wall before standing up. Lewis stood by and observed as the entire incident took place.

- Lewis stated as the youths were being searched by Smith, the youths started playing around and saying other youths were hiding snacks and attempting to take them back to the module. Lewis viewed video surveillance with OIG staff and confirmed Rios and Smith engaged in horseplay with youth Perez and the other unidentified youths. Lewis stated the conduct was due to the module having a number of youths. Lewis stated he did not participate because he knew engaging in horseplay with the youths is prohibited.[13]

- Rios stated he engaged in horseplay with an unidentified youth during a search by picking him up and dropping him on his feet. Rios stated he engaged in horseplay with a second unidentified youth during a search by picking him up and tossing him on his feet toward a wall. Rios stated he assisted Smith with lifting youth Perez into the air for the purpose of trying to search youth Perez and remove suspected snacks from his jumper. Rios stated the searches were not done properly. Rios stated engaging in horseplay with the youths is prohibited. Rios stated the incident was due to the module having a low number of youths and was the result of a lapse in judgment.[14]

- Smith stated he engaged in horseplay with an unidentified youth during a search by picking him up and dropping him on his feet. Smith stated he engaged in horseplay with a second unidentified youth during a search by picking him up by his uniform and swinging him perpendicular to the floor. Smith stated he engaged in horseplay with youth Perez during a search by lifting him off his feet and dropping him on his feet. Smith stated while he searched youth Perez a second time, he and Rios engaged in horseplay with youth Perez by lifting him into the air and dropping him on his feet. Smith stated his conduct was due to the module having a low number of youths. Smith stated horseplay is prohibited by policy and can lead to more serious issues.[15]

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Smith** and **Rios** engaged in improper searches and horseplay with

[11] Exhibit 36
[12] Exhibit 35
[13] Exhibit 58
[14] Exhibit 62
[15] Exhibit 63

youth Perez and four other unidentified youths. Therefore, a finding of **SUSTAINED** is recommended in this matter.

4. **Violation of Policy/Rule and is covered by Palm Beach RJDC FOP # 0.018, Facility Standards of Ethical Behavior.**

During this investigation, testimony was received and documents were reviewed related to **Juvenile Justice Detention Officer I Christian Lewis'** failure to report the conduct of Rios and Smith.

- Lewis stated he felt it was "ok" to be more relaxed when the module has a low number of youths; therefore, he did not report the conduct to the shift supervisor because he accepted that Rios and Smith were just playing with the youths and nobody was hurt. Lewis stated he knew that engaging in horseplay with the youths was prohibited, and that the searches were not done properly. Lewis stated he should have reported what he observed.[16]

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Lewis** failed to report Smith and Rios who had engaged in improper searches and horseplay with youth Perez and four other unidentified youths. Therefore, a finding of **SUSTAINED** is recommended in this matter.

5. **Violation of Florida Administrative Code 60L-36.005 disciplinary standards, State of Florida Employee Code of Conduct, and Palm Beach RJDC Facility Operating Procedure (FOP) # 4.10 by not following procedures for non-life threatening emergencies and non-staffed clinic hours.**

During this investigation, testimony was received and documents were reviewed related to **Juvenile Justice Detention Officer Supervisor Terence Davis'** and **Juvenile Justice Detention Officer II Floyd Powell's** failure to follow procedures for non-life threatening emergencies and non-staffed clinic hours. From this activity, the following facts were established:

- JJDO I Souffrant stated while she was in the hallway outside of the B-2 module, she heard Davis tell Lewis that youth Perez was "faking" and "wanting to go to Columbia Hospital to escape because his parents did not want him." Souffrant stated Davis proceeded to demonstrate how youth Perez was "faking" by performing body motions and referencing youth Perez falling into the table. Souffrant stated she heard Davis say he was not going to transport youth Perez to Columbia Hospital because he "did not want to complete a CCC report."[17]

- JJDO I Lydia Sanchez stated Davis entered the B-1 module and referred to a youth who was "acting up," "seeing things", and "saying somebody was on him." Sanchez stated Davis entered the B-1 module a second time and stated youth Perez had vomited, "seemed lost", and "may be high from eating paint." Sanchez stated Davis also expressed his belief that youth Perez was "trying to go to Columbia Hospital so he could escape." Sanchez stated Davis did not appear concerned and was not treating the situation as an emergency.[18]

- Flowers stated Davis contacted him twice by telephone, but did not provide any information suggesting youth Perez's condition required calling 9-1-1. Flowers stated Davis only said youth

[16] Exhibit 58
[17] Exhibit 32
[18] Exhibit 31

Perez woke up screaming, vomited, and fell asleep; therefore, Flowers directed Davis to call the nurse (Registered Nurse Diana Heras) for further direction.[19]

- Paul was assigned to Master Control and stated he went on break between approximately 1:00 a.m. and 2:00 a.m.[20] Paul stated after he returned from the break, he noticed on the surveillance monitor multiple staff standing around a youth (youth Perez) lying on a mat in the B-2 module. Paul stated he used the intercom to call the module and gather information, but did not receive a response. Paul stated he later saw what looked like unidentified staff trying to move youth Perez to the bathroom, but the camera view made it difficult for Paul to clearly determine what was happening. Paul stated Davis entered Master Control shortly afterward and said youth Perez was sick and that Davis needed to call the nurse (Heras), per Flowers. Paul stated Davis attempted to contact Heras twice by telephone, but was unsuccessful and did not appear alarmed or panicked. Paul stated around the same time from one of the calls, he heard Davis make a comment to Jarrell about "women who can fake pregnancy and make themselves vomit." Paul stated he heard Jarrell say youth Perez defecated on himself, but Paul did not see this as odd because he had worked with youths who displayed similar behavior. Paul stated no staff approached him about the need to call 9-1-1, and based on his observations, no staff acted as if 9-1-1 needed to be called. Paul stated he did not identify any signs of an emergency because he was given limited information, he was not in the module to observe youth Perez firsthand, and the other staff appeared to be handling the situation.

- King stated she entered the B-2 module in response to a radio call for assistance and observed youth Perez leaning over on a mat and appearing quiet, lethargic, and "doped up" and he had already vomited. King stated youth Perez lay on the bare floor for an extended amount of time, but she considered the situation as simply a youth who was really sick and being tended to by the officers who had more information than her.[21]

- King stated she returned to the module approximately two hours later and saw youth Perez lying down on a mat and she became concerned about youth Perez's condition when he did not respond to her verbal prompts. King stated she later saw Davis and Powell attempt to assist youth Perez to the bathroom, but he was "too lethargic" and still looked "doped up." King stated Powell mentioned the need to call 9-1-1, but Davis decided to call Flowers. King stated Davis later said he was told by Flowers to hold off calling 9-1-1 and to call the nurse instead. King stated she could have called 9-1-1 without repercussions, but did not see the situation as necessitating it at the time and considered Davis as in control and determining the plan of action. King stated her lack of action was due to a sense of fear and apprehension about "overstepping authority." [22]

- Jarrell stated he entered the B-2 module and was told by Powell that youth Perez was put on the dayroom floor because he was making noises in his room and "hallucinating." Jarrell stated he saw youth Perez sit up and start to vomit from his mouth and nose. Jarrell stated he saw Davis and Powell subsequently attempt several times to assist youth Perez from the floor and escort him to the bathroom, but youth Perez fell back to the floor and was unable to walk on his own. Jarrell stated he heard Powell say he was going to call 9-1-1, but Davis told him "no" due to the situation "not being a life threatening emergency." Jarrell stated he suggested to Davis that

[19] Exhibit 18
[20] Exhibit 16
[21] Exhibit 60
[22] *Id.*

Flowers be contacted and later he saw Davis in Master Control and Davis indicated that Flowers told him to call the nurse. Jarrell stated he heard Davis say he thought youth Perez was "faking" his illness and "some women want to be pregnant and think they are pregnant, so they force themselves to vomit." Jarrell stated he "believed" he completed 9-1-1 training, but stated calling 9-1-1 "is up to the supervisor." Jarrell stated he was unsure of the 9-1-1 policy and that signs giving staff authority to contact 9-1-1 are not posted in the modules.[23]

- Lewis stated he returned to the B-2 module from a break and saw youth Perez lying on a mat on the dayroom floor. Lewis stated Davis told him youth Perez was "hallucinating." Lewis stated that 15-20 minutes later, youth Perez sat up and vomited from his mouth and nose. Lewis stated he, Powell, and King discussed calling 9-1-1, but Davis responded "no" to the suggestion and preferred to call Flowers first. Lewis stated he saw Davis in the supervisor's office after Davis spoke with Flowers and Davis' demeanor gave the impression that the situation was not an emergency. Lewis stated he later heard Davis make comments alluding to youth Perez "faking" his condition because he was friends with and in the same gang as another youth who allegedly faked an illness as an attempt to get out of the module and the facility.[24]

- Lewis stated as the night progressed, he believed youth Perez was "ok" after he vomited because he fell asleep and snored. Lewis stated he only did what Davis directed him to do at the time, but stated in hindsight the situation should not have gone on as long as it did and 9-1-1 should have been contacted sooner. Lewis stated he received prior 9-1-1 training and was aware any staff can call at any time. Lewis stated he did not call 9-1-1 because, "You wanted to do something, but you feel like if you do it, you will get in trouble because you were already told not to do it." Lewis stated the situation was "confusing" and he was not sure if there would have been repercussions or consequences for taking control and calling 9-1-1 despite Davis' directives.[25]

- Powell stated he was alone in the B-2 module and conducting 10-minute room checks when he approached youth Perez's room and saw youth Perez walking around and crying. Powell stated he called Davis to the module. Powell stated youth Perez exited the room and fell to the floor while crying unintelligibly. Powell stated youth Perez was unable to walk on his own and subsequently vomited on himself from his mouth and possibly his nose. Powell stated Davis returned to the module and Powell proceeded toward the module's sub-control room to call 9-1-1, but Davis directed him not to.[26] Powell stated Davis' body language and demeanor gave the impression that the youth's condition "was no big deal" and "not life threatening." Powell stated there would not have been a problem if he called 9-1-1 despite Davis' directives. Powell stated he could have notified Master Control by radio to call 9-1-1. Powell stated Davis later told him he spoke with Flowers and was directed to call the nurse and not 9-1-1. Powell stated youth Perez fell asleep and snored, so Powell thought he was "ok." Powell stated youth Perez "looked dead" prior to being moved to medical confinement, but he was still breathing and snoring.[27]

- Davis stated he responded to the B-2 module "for a serious issue" and at the request of Powell and observed youth Perez walking around his room and yelling, "Get off of me" and "I can't hear!"[28] Davis stated he opened the room door and youth Perez stumbled out "like he was

[23] Exhibit 59
[24] Exhibit 58
[25] *Id.*
[26] Exhibit 27
[27] Exhibit 57
[28] Exhibit 56

intoxicated." Davis stated youth Perez walked around the module and sat down at a table and expressed he "wanted the pain in his head to go away." Davis stated youth Perez did not fall and hit the table, but instead "broke his fall and must have been coherent enough to do so." Davis stated he knew something was wrong with youth Perez, but was trying to determine to what extent. Davis stated he assisted youth Perez to a mat on the dayroom floor, where he fell asleep. Davis stated youth Perez's verbalizations ceased and "everything changed" after he was allowed out of the room, thus leading Davis to state it was "possible" and "there was a potential" that youth Perez was faking his condition. Davis stated Powell called him back to the module after youth Perez woke up and vomited. Davis stated he attempted to assist youth Perez to the bathroom for a shower, but youth Perez "didn't have enough strength because he lost so much fluid." Davis stated Powell mentioned calling 9-1-1 only one time. Davis denied Powell attempted to call or was prevented from calling. Davis stated he did not object to calling 9-1-1, but was unsure if it was necessary because youth Perez fell asleep; therefore, Davis opted to contact Flowers, who in turn said to call the nurse. Davis stated he did not recognize the situation as life threatening at that point and figured youth Perez "wanted sleep," and "whatever was in his system, he vomited and got it out." Davis stated his goal was to keep youth Perez comfortable until a nurse arrived. Davis stated 9-1-1 should have been called sooner.[29]

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Davis** and **Powell** failed to follow procedures for non-life threatening emergencies and non-staffed clinic hours. Therefore, a finding of **SUSTAINED** is recommended in this matter.

6. **Violation of Florida Administrative Code 60L-36.005 disciplinary standards, State of Florida Employee Code of Conduct, and Palm Beach RJDC Facility Operating Procedure (FOP) # 4.10 and by not following procedures for failing to provide proper supervision of youth.**

During this investigation, testimony was received and documents were reviewed related to **Juvenile Justice Detention Officer II Marlon Jarrell's** failure of providing proper supervision of youth. From this activity, the following facts were established:

- Jarrell stated he lifted youth Perez's mat to prevent him from choking while he was vomiting and this caused youth Perez to fall to the side. Jarrell acknowledged that youth Perez was left on the bare floor, but he provided no explanation other than his belief that youth Perez was still vomiting. Jarrell stated he approached youth Perez and attempted to communicate with him, but youth Perez "just looked up at me and didn't say anything." Jarrell stated he observed Davis and Powell subsequently attempt several times to assist youth Perez from the floor and escort him to the bathroom, but youth Perez fell back to the floor and was unable to walk on his own. Jarrell returned to the B-2 module and noticed youth Perez was still on the bare floor, so he re-positioned him on the mat. Jarrell stated no further discussion of 9-1-1 took place prior to him exiting the module for the final time.[30]

- Jarrell's statement that he "believed" he previously attended 9-1-1 training, but claimed calling 9-1-1 "is up to the supervisor." Jarrell claimed he was unsure of the 9-1-1 policy and that signs are not posted in the modules.[31]

[29] Exhibit 56
[30] Exhibit 59
[31] *Id.*

- Jarrell acknowledged in hindsight during both interviews that 9-1-1 should have been called due to youth Perez's condition; however, at the time of the incident he deferred to the direction and judgment of Davis.[32]

Based on the testimony received as well as information determined from analyzed data and other documents, it can be determined that **Jarrell** failed to provide proper supervision of youth. Therefore, a finding of **SUSTAINED** is recommended in this matter.

V. ADDITIONAL RECOMMENDATIONS/ACTIONS TAKEN

A. As to Recommendations/Actions Taken:

1. Dismissals

- Anthony Flower's dismissal letter from DJJ, dated December 27, 2011 - Flowers was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a), (b), (c) and (e); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, and # 5 Violation of Law or Agency Rules.[33]

- Terence Davis' dismissal letter from DJJ, dated July 14, 2011 - Davis was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a) (2), (b), (c) and (e); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, and # 5 Violation of Law or Agency Rules. Additionally, Davis violated Palm Beach RJDC Facility Operating Procedure (FOP) # 4.10 by not following the procedures for non-life threatening emergencies and non-staffed clinic hours.[34]

- Floyd Powell's dismissal letter from DJJ, dated July 14, 2011 - Powell was dismissed as the result of failing to satisfactorily complete his probationary period.[35]

- Laryell King's dismissal letter from DJJ, dated July 29, 2011 - King was dismissed as the result of failing to satisfactorily complete her probationary period.[36]

- Christian Lewis' dismissal letter from DJJ, dated January 9, 2012 - Lewis was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a)(2), (b), (c), (e), (f) and (g); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, # 6 Conduct Unbecoming a Public Employee and # 7 Misconduct. Additionally, Lewis failed to ensure the safety of the youths under his supervision and the security of the facility when he observed two other officers not properly searching the youths and engaging in unauthorized physical contact or horseplay with the youths. Therefore,

[32] *Id.*
[33] Exhibit 37
[34] Exhibit 38
[35] Exhibit 39
[36] Exhibit 40

Lewis violated Palm Beach RJDC FOPs # 0.018 and # 1.03 when he failed to report the incident.[37]

- Alberto Rios' dismissal letter from DJJ, dated January 9, 2012 - Rios was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a)(2), (b), (c), (e), (f) and (g); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, # 5 Violation of Law or Agency Rules, # 6 Conduct Unbecoming a Public Employee and # 7 Misconduct. Additionally, Rios violated Palm Beach RJDC FOPs # 0.018 and # 5.01 by not properly searching the youths and engaging in unauthorized physical contact or horseplay with the youths.[38]

- Marlon Jarrell's dismissal letter from DJJ, dated January 9, 2012 - Jarrell was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a)(2), (b), (c) and (e); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, and # 5 Violation of Law or Agency Rules. Additionally, Jarrell violated Palm Beach RJDC FOP # 4.10 by not following the procedures for non-staffed clinic hours, and violated FOP # 5.01 by failing to provide proper supervision of the youth.[39]

- Darrell Smith's dismissal letter from DJJ, dated January 9, 2012 - Smith was dismissed as the result of violating disciplinary standards set forth in Florida Administrative Code 60L-36.005 (3) (a)(2), (b), (c), (e), (f) and (g); and for violating State of Florida Employee Standards of Conduct # 1 Poor Performance, # 2 Negligence, # 3 Inefficiency or Inability to Perform Assigned Duties, # 5 Violation of Law or Agency Rules, # 6 Conduct Unbecoming a Public Employee and # 7 Misconduct. Additionally, Smith violated Palm Beach RJDC FOPs # 0.018 and # 5.01 by not properly searching the youths and engaging in unauthorized physical contact or horseplay with the youths.[40]

Based on the fact that all subjects have been dismissed, completion of OIG Incident/Complaint Disposition Forms is not required.

2. Grand Jury

The following recommendations were made by the Grand Jury as they pertain to DJJ:

- Training of the DJJ Officers should be as extensive as the training required of sworn correctional officers.

- Policies and procedures for the DJJ officers should require that any youth complaining of a medical condition should be immediately seen by a medical professional to evaluate whether emergency services are necessary.

- The DJJ must have a medical professional on site at the juvenile detention center at all times to evaluate any youth complaining of medical difficulties if there is no medical

[37] Exhibit 41
[38] Exhibit 42
[39] Exhibit 43
[40] Exhibit 44

professional available to the child, the officers should be required to call 911 for outside medical assistance.

3. Detention Services Response

Under the direction of Assistant Secretary Julia Strange, Detention Services documented DJJ's response following the death of youth Perez. This response included activities that are defined in a document entitled ***Detention Services Responses.***[41] This document was reviewed for this investigative report and covered activities or actions taken between July 10, 2011 and July 2, 2012. Specific actions/activities pertinent to this investigation are as follows:

- July 11, 2011 - Directive issued by Assistant Secretary Strange to Regional Directors to ensure all detention centers review 9-1-1 protocol reiterating they do not need permission to access emergency services if they deem an individual to be a medical or mental health crisis.

- July 13, 2011 – JJDO I Layrell King placed on Administrative Leave; JJDO II Marion Jarrell placed on Administrative Leave; JJDO I Christian Lewis placed on Administrative Leave.

- July 15, 2011 - Floyd Powell and Terrence Davis are terminated.

- July 20, 2011: Letter from Secretary Walters to all DJJ employees to provide an update on the agency's response and position. The letter reiterated that keeping the youth in our custody safe is of paramount importance. The letter reminded all staff and especially those directly responsible for the youth we serve, or the following:

    - Call 9-1-1 without delay if there is any concern for the health of a youth that cannot be addressed by medical staff on site.

    - DJJ and contracted facilities must provide youth with unrestricted access to the statewide child abuse hotline at 1.800.96.ABUSE.

    - DJJ maintains a 24-hour toll-free incident hotline for anyone to report any concerns regarding our youth or the juvenile justice system.

- July 27, 2011 – Medication Administration and Designated Health Authority notification training conducted by Registered Nursing Consultant Pat Head and Regional Nurse Manager for Corizon/Prison Health Services Tish Wright.

- July 30, 2011 - JJDO I Layrell King terminated.

- August 4, 2011 – 9-1-1 posters developed and distributed for posting in all detention centers reiterating that a person (employee) does not need permission to call 9-1-1.

- August 11, 2011: JJDO I Darrel Smith and JJDO " Alberto Rios placed on Administrative Leave.

[41] Exhibit 53

- August 22, 2011: Weekly conference calls begin to discuss policies, procedures, and practices at the center. Participants include Directors Rick Bedson and Lois Salton, OPM Marc Jacoby, SMA Sharon Shore, St. Lucie Superintendent Kevin Housel, Broward Superintendent Daryl Wolf and Miami-Dade Superintendent Cornelius Faulk.

- September 6-9 2011: A Technical Assistance review team is established to include Marc Jacoby, Sharon Shore, Rick Bedson, Kevin Housel, Government Operations Consultant Michele Brandon, Assistant Detention Superintendent Mae Foley, Senior Behavior Specialist Leslie Swanson and Patricia Head, Registered Nursing Consultant to complete a comprehensive audit of the policies, procedures, and practices at Palm Beach.

- October 3-4 2011: Pat Head reviewed the progress made on the Quality Improvement Plan (QIP) by reviewing additional healthcare records, medication administration records, tracking logs and JJIS alerts.

- November 8-9, 2011: Pat Head conducts additional training on calling 9-1-1 and DHA notification.

- November 10, 2011: The results of the medical services review and the quality improvement plan presented to the management team at Palm Beach Detention. Participants included Pat Hammond, JJDOs Teri Finley, Michele Brandon, Leslie Swanson, and Pat Head.

- Quality Assurance (QA) Assistance Team developed and led by Broward Superintendent Daryl Wolf and Miami-Dade Detention Superintendent Cornelius Faulk to assist the facility in better understanding the mandates and expectations of a QA review.

- December 5, 2011: Superintendent oversight of Palm Beach Detention assigned to Daryl Wolf and Kevin Housel.

- December 27, 2011: Anthony Flowers was terminated.

- January 5, 2012: Assistant Secretary Julia Strange creates a workgroup to develop an Annual Internal Audit for Detention Services. The audit will serve as a tool to assess compliance with policy and procedure through the observation of practical application at all 21 state-operated detention centers.

- January 9, 2012: Marlon Jarrell, Christian Lewis, Alberto Rios, and Darrell Smith terminated.

- February 13-15, 2012: Deputy Secretary Robert Woody and Detention Chief Wanda Harper travel to Palm Beach County to meet with Judge Ronald V. Alvarez, Commissioner Shelley Vana to address the current conditions at the facility, employee morale, and concerns raised by the community regarding the safety of the youth at the center.

    - A prepared statement by Assistant Secretary Strange is read to all Palm Beach RJDC personnel addressing each concern and to support their-efforts, during the transition period.

- February 14, 2012: Deputy Secretary Woody and Wanda Harper met with Palm Beach County stakeholders at the county court house. Participants included judges, state attorneys, public defenders, members of the Juvenile Justice Circuit 15 Board; and members of the faith based community.

- February 16, 2012: Deputy Secretary Robert Woody and Detention Chief Wanda Harper meet with individual youth at the center.

- March 7, 2012: At the invitation of the state attorney, Rick Bedson presents before the Palm Beach County Grand Jury to provide information about DJJ's detention services, the Palm Beach Juvenile Detention Center policies and procedures, staffing, training, medical services, and other aspects of detention, as well as the circumstances of Eric's stay at the detention center, the events leading up to his death, and the actions subsequently taken by DJJ General Counsel Brian Berkowitz and Assistant Secretary Strange.

- March 14, 2012: A meeting was called for members of the Executive Leadership Team to review the findings of the Grand Jury Report and develop strategies to address the findings. The members of the team included Chief of Staff Christy Daly, Deputy Secretary Robert Woody, Chief of Investigations Keith Morris, General Counsel Brian Berkowitz, Medical Director Dr. Lisa Johnson, Assistant Secretary for Detention Services Julia Strange, and Communications Director C.J. Drake.

- March 27-29, 2012: Representatives from Detention Services participated on a workgroup to address the implementation of the Ergometrics system within Detention. Ergometrics' IMPACT product, The Human Relations Video Test, is designed to screen potential candidates for employment in direct care positions in the juvenile justice system this validated to measure overall suitability for working with juvenile offenders. *A.* comprehensive review took place which included participants taking the Impact Human Relations Video Test and evaluating the Impact curriculum for juvenile justice personnel.

- April 4, 2012: Memo distributed to *All Detention Personnel* from Assistant Secretary Julia Strange reiterating 9-1-1 Procedures and Expectations.

- May 8-11, 2012: Superintendent's Training Conference facilitated by Assistant Secretary Strange. Participants included superintendents, detention chiefs, detention directors, Secretary Wansley Walters, Chief of Staff Christy Daly, Deputy Secretary Robert Woody, Director of Staff Development and Training Brenda Posthumus, Director of Health Services, Dr. Lisa Johnson, Communications Director C.J. Drake, Chief of Research and Planning Mark Greenwald, and Danielle Lipow from the Casey Foundation. Topics included but not limited to:

    - Detention Reform
    - Managing Change and Transition
    - Responding to Health Related Emergencies
    - Annual Internal Audits
    - Re-Inventing Detention Services
    - Trauma-Informed Care

- Juvenile Justice Trends
- Juvenile Detention Alternative Initiative

- June 20, 2012: Conference call held with representatives from Detention Services, Personnel and Staff Development to discuss the implementation of Ergometrics on July 1, [2012].

- June 21, 2012: Chuck Parkins appointed to the Superintendent position at Palm Beach Detention Center effective June 29, 2012.

4. **Corrective Action Plan (CAP)**[42] – Under the direction of Assistant Secretary Strange a comprehensive plan was developed and addresses the following areas:

   - Admission and Orientation
   - Management Accountability
   - Behavior Management
   - Physical Plant Inspections
   - Medical
   - Mental Health
   - Training
   - Personnel
   - Safety and Security
   - General

   The CAP delineates the following for each area previously identified:

   - Issue
   - Action Taken
   - Target Completion Date
   - Person Responsible
   - Completed Date
   - Reviewed by: (or approving authority of action taken)

   The CAP as stated is comprehensive and is included within the case file for review.

5. **Annual Audit Plan 2012-2013** – The OIG Bureau of Internal Audit will undertake an audit of the Palm Beach Detention Center Operations in September 2012. The audit will assess the corrective actions implemented for deficiencies identified by a Technical Assistance review team conducted September 6-9 2011. The team included Marc Jacoby, Sharon Shore, Rick Bedson, Kevin Housel, Government Operations Consultant Michele Brandon, Assistant Detention Superintendent Mae Foley, Senior Behavior Specialist Leslie Swanson, and Patricia Head, Registered Nursing Consultant.

[42] Exhibit 54

VI. SUBJECTS

Former Superintendent Anthony Flowers was employed at Palm Beach RJDC for eight years and two months. The BSU database showed that at the time of the incident, Flowers was eligible for employment. The CCC database showed zero complaints were made against Flowers.

Former Juvenile Justice Detention Officer Supervisor Terence Davis was employed at Palm Beach RJDC for 11 months. The Background Screening Unit (BSU) database showed that at the time of the incident, Davis was eligible for employment. The CCC database showed zero complaints were made against Davis.

Former Juvenile Justice Detention Officer II Floyd Powell was employed at Palm Beach RJDC for approximately four years. The BSU database showed that at the time of the incident, Powell was eligible for employment. The CCC database showed one complaint was made against Powell. An Administrative Review unsubstantiated an allegation of Excessive Force and substantiated an allegation of Violation of Policy/Rule (CCC # 2011-00477). Powell received a reprimand.

Former Juvenile Justice Detention Officer I Christian Lewis was employed at Palm Beach RJDC for one year and ten months. The BSU database showed that at the time of the incident, Lewis was eligible for employment. The CCC database showed zero complaints were made against Lewis.

Former Juvenile Justice Detention Officer II Marlon Jarrell was employed at Palm Beach RJDC for three years and eleven months. The BSU database showed that at the time of the incident, Jarrell was eligible for employment. The CCC database showed two complaints were made against Jarrell. An Administrative Review determined an allegation of Improper Supervision was inconclusive (CCC # 2008-00247). Jarrell resigned during the course of the review. An Administrative Review unsubstantiated an allegation of Unnecessary Force and substantiated an allegation of Violation of Policy/Rule (CCC # 2011-00477). Jarrell received a reprimand.

Former Juvenile Justice Detention Officer I Laryell King was employed at Palm Beach RJDC for 10 months. The BSU database showed that at the time of the incident, King was eligible for employment. The CCC database showed zero complaints were made against King.

Licensed Practical Nurse Marcia Clough was employed at Palm Beach RJDC for two years and seven months. The BSU database showed that at the time of the incident, Clough was eligible for employment. The CCC database showed zero complaints were made against Clough.

Former Juvenile Justice Detention Officer I Alberto Rios was employed at Palm Beach RJDC for three years and seven months. The BSU database showed that at the time of the incident, Rios was eligible for employment. The CCC database showed two complaints were made against Rios. A Program Review unsubstantiated an allegation of Unnecessary Force and substantiated an allegation of Violation of Policy/Rule (CCC # 2010-01157). Rios received a reprimand. An Administrative Review unsubstantiated an allegation of Improper Conduct (2011-00477).

Former Juvenile Justice Detention Officer I Darrell Smith was employed at Palm Beach RJDC for one year and seven months. The BSU database showed that at the time of the incident, Smith was eligible for employment. The CCC database showed zero complaints were made against Smith.

VII. STATEMENT OF ACCORDANCE

Section 20.055, Florida Statutes, establishes the 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.

VIII. EXHIBIT LIST

1. Probation Medical and Mental Health Clearance Form for youth Perez
2. Secure Detention Admission Wizard for youth Perez
3. Medical and Mental Health Admission Screening for youth Perez
4. Medical and Mental Health Screening Form Attachment for youth Perez
5. Sick Call Request for youth Perez
6. Sick Call Index for youth Perez
7. Health-Related History (HRH) Form for youth Perez
8. Comprehensive Physical Assessment (CPA) for youth Perez
9. Doctor's Progress Notes
10. Chronic Condition Notification for youth Perez
11. Medical Progress Notes for youth Perez
12. Confinement Report
13. Incident Report by JJDO II Floyd Powell, dated July 10, 2011
14. B-2 Module logbook entries for July 9, 2011
15. B-2 Module logbook entries for July 10, 2011
16. Master Control logbook entries from July 10, 2011
17. Written statement from Licensed Practical Nurse Marcia Clough, dated July 10, 2011
18. Written statement from former Superintendent Anthony Flowers dated July 10, 2011
19. Collected photographic evidence from youth Perez's room (# 11), the B-2 module, the B-2 sub-control room, and confinement room # D-4
20. Video surveillance of the B-2 module
21. Video surveillance of confinement room # D-4
22. Electronic room check logs for the B-2 module from July 9-10, 2011.
23. Electronic room check logs for the D-4 confinement room from July 10, 2011.

24. Training documentation consisting of sign-in sheets and CORE account printouts covering July 2012 to July 2011.
25. Written statement from Registered Nurse Diana Heras, dated July 13, 2011
26. Incident Report by Lewis, dated July 10, 2011
27. Incident Report by JJDO II Marlon Jarrell, dated July 10, 2011
28. Incident Report by JJDO I Laryell King, dated July 10, 2011
29. Incident Report by Davis, dated July 10, 2011
30. Incident Report by JJDO II Randolph Roberts, dated July 10, 2011
31. Incident Report by JJDO I Lydia Sanchez, dated July 15, 2011
32. Incident Report by JJDO I Mismaille Souffrant, dated July 15, 2011
33. Incident Report by JJDO I Morris Drayton, dated July 18, 2011
34. Cell phone usage log for Superintendent Anthony Flowers
35. Video surveillance of the cafeteria
36. Training documentation consisting of CORE account printouts, covering July 2010 to July 2011
37. Dismissal letter for Flowers, dated December 27, 2011
38. Dismissal letter for Davis, dated July 14, 2011
39. Dismissal letter for Powell, dated July 14, 2011
40. Dismissal letter for King, dated July 29, 2011
41. Dismissal letter for Lewis, dated January 9, 2012
42. Dismissal letter for Rios, dated January 9, 2012
43. Dismissal letter for Jarrell, dated January 9, 2012
44. Dismissal letter for Smith, dated January 9, 2012
45. E-mail sent to Corizon Health, Inc. [formerly Prison Health Services Regional Manager] Tish Wright, dated July 11, 2011

46. E-mail sent to OIG staff, dated March 14, 2012
47. Collected photographs of the Palm Beach RJDC Master Control room.
48. Presentment of the Palm Beach County Grand Jury, dated March 8, 2012
49. Palm Beach County Medical Examiner report for youth Perez.
50. Diagram detailing the configuration of the B-2 module.
51. Still images generated from video surveillance footage of the B-2 module.
52. Still images generated from video surveillance footage of the cafeteria.
53. Detention Services Response
54. Corrective Action Plan (CAP)
55. Sworn/Recorded Interview of Former Superintendent Anthony Flowers
56. Sworn/Recorded Interview of Former JJDOS Terence Davis
57. Sworn/Recorded Interview of Former JJDO II Floyd Powell
58. Sworn/Recorded Interview of Former JJDO I Christian Lewis
59. Sworn/Recorded Interview of Former JJDO II Marlon Jarell
60. Sworn/Recorded Interview of Former JJDO I Laryell King
61. Sworn/Recorded Interview of LPN Marcia Clough
62. Sworn/Recorded Interview of Former JJDO I Alebrto Rios
63. Sworn/Recorded Interview of Former JJDO II Darrell Smith

IX. DISTRIBUTION LIST

Action Official Distribution:

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

Information Distribution:

Copies of the Executive Summary, without exhibits or attachments, have been distributed electronically to:
Wansley Walters, Secretary
Christy Daly, Deputy Secretary

Files:

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