IN THE CIRCUIT COURT OF THE
FIFTEENTH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA

FINAL REPORT
OF THE
PALM BEACH COUNTY GRAND JURY

INVESTIGATION OF FLORIDA INSTITUTE FOR GIRLS

FALL TERM A.D. 2003

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INVESTIGATION INTO PREMIER BEHAVIORAL SOLUTIONS d/b/a FLORIDA INSTITUTE FOR GIRLS and THE FLORIDA DEPARTMENT OF JUVENILE JUSTICE

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IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT
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IN RE: UNANIMOUS REPORT OF THE GRAND JURY CONCERNING PREMIER BEHAVIORAL SOLUTIONS D/B/A FLORIDA INSTITUTE FOR GIRLS AND THE DEPARTMENT OF JUVENILE JUSTICE.

IN THE NAME AND BY THE AUTHORITY BY THE STATE OF FLORIDA

The Grand Jury presentment on Premier Behavioral Solutions d/b/a Florida Institute for Girls and the Florida Department of Juvenile Justice.

In May 2003, a news reporter conveyed to a Juvenile Court Judge concerns about the Florida Institute for Girls, a High/Maximum Risk correctional facility for teenage girls who have committed criminal acts, many who have mental health needs. The packet given to the judge, containing 24 reports about alleged abuse of the girls, painted a disturbing picture. The juvenile judge forwarded this information to the Chief Judge who asked Palm Beach County State Attorney, Barry E. Krischer, to look into the allegations. The State Attorney convened this Grand Jury to investigate issues concerning the safety and well-being of the girls incarcerated in the Florida Institute for Girls.

The Florida Institute for Girls (hereinafter referred to as F.I.G.) is located in Palm Beach County and receives public money through the Department of Juvenile Justice (hereinafter referred to as D.J.J.) contracted dollars. The acceptance of public funds places Premier within the jurisdiction of this Grand Jury.

On October 7, 2003, the Fall term Grand Jury was sworn in. Over the last four months this Grand Jury heard testimony from 39 witnesses including therapists, female juvenile offenders, staff (past and present), management (past and present), law enforcement, and representatives of the Department of Children and Families (hereinafter

referred to as D.C.F.) and D.J.J. The Grand Jury reviewed more than one thousand pages of documents, numerous security tapes, videos and photographs.

This investigation focused on D.J.J. and a private for-profit corporation called Premier Behavioral Solutions f/k/a as Ramsay Youth Services, Inc. (hereinafter referred to as Premier), the contracted provider responsible for F.I.G.

A brief explanation of the Juvenile Justice system is necessary to understand the issues of this investigation.

Any child under the age of eighteen (18) who commits a criminal-type offense falls within the jurisdiction of the Juvenile Court. This Court proceeds in a similar fashion to adult court including the presentation of evidence at a non-jury trial, ensuring that all constitutional rights are protected. At the sentencing phase juvenile court diverges from its adult counterpart. Once a juvenile is found guilty of violating the law, the judge has two options at sentencing. The first is probation, where the court allows the juvenile to remain at home under stringent rules and with certain sanctions. The second is commitment, where the juvenile is removed from the home and placed in a facility operated through D.J.J.

When the court chooses the option of commitment, D.J.J. has a staffing to determine its commitment level recommendation. The commitment staffing includes the juvenile offender, the juvenile's parent, the juvenile's attorney, a school representative, a mental health representative, the juvenile probation officer and a commitment specialist. The result of this staffing is a determination from D.J.J.'s perspective as to which level of commitment is required to meet the juvenile offender's needs while still maintaining public safety.

There are four levels of commitment. Low Risk Residential is for the least violent offenders who need short-term residential care in a non-secure environment. Moderate Risk Residential is for offenders who have repeated convictions for crimes and need twenty four (24) hour supervision. High Risk Residential is for all serious juvenile offenders who need approximately twelve (12) months of programming and treatment in a secure environment. Maximum Risk Residential is for the most serious juvenile offenders who will serve 18-36 months in a maximum security environment.

F.I.G. is a combined High Risk/Maximum Risk Residential Commitment Program. Girls who are committed to the High Risk program are serious offenders who are to serve approximately twelve months if their behavior is good and they successfully move through each level of the program. Girls who are committed to the Maximum Risk program are the most serious offenders who are to serve a minimum of eighteen (18) months and a maximum of thirty six (36) months.

F.I.G. is the only Maximum Risk Program for Girls in the State of Florida and only one of a few in the nation. It was developed and opened in April of 2000 to house fifty (50) of the most serious delinquent girls. In 2001, the legislature appropriated money for an additional fifty (50) beds with the stipulation that these beds handle the serious delinquent girls who also have major mental health issues. As the only facility in Florida for teenage girls whose mental health issues cause their behavior to be unmanageable by any other juvenile commitment program in the State, the beds filled quickly.

EXECUTIVE SUMMARY

The initial matter investigated by the Grand Jury was a reporter's packet of select incident reports from F.I.G. This packet reflected only twenty four (24) of over 300 reports reviewed by the Grand Jury. From the outward appearance of the incidents, one would certainly think that Florida Institute for Girls and the Department of Juvenile Justice were not taking the necessary steps to address the safety and well-being of the girls incarcerated at F.I.G. Taken alone, these twenty four (24) reports painted a picture of numerous abuses to the girls that were somehow covered up or eluded investigation.

However, testimony of thirty nine (39) witnesses and review of over one thousand documents revealed no evidence of systemic cover-up of abuse allegations by D.J.J. or Premier. Evidence reflected investigations of the girls' abuse allegations were completed by as many as three different agencies.

This investigation did uncover other serious issues affecting the safety of the girls and staff at this facility. Hundreds of incident reports were logged at F.I.G. The issues behind these reports became the major focus of this investigation.

Even though the quantity of incident reports originating from F.I.G. could not be benchmarked against similar facilities in Florida (since there are none), the volume seemed high, and was having a negative impact on resources at F.I.G., D.J.J., D.C.F. and the Palm Beach County Sheriff's Office (hereinafter referred to as P.B.S.O.). Each incident was properly investigated. Results were reviewed by the Grand Jury and it finds that a small number of girls at F.I.G. were found to have generated a high number of the incident reports. More than an estimated 75% of the reports involving abuse allegations were unfounded or false.

Anytime an incident was determined to have involved inappropriate conduct by staff, the situation was dealt with immediately and appropriately through internal procedures and the legal system. Any allegation resulted in F.I.G. management instantaneously removing the staff from direct contact with that girl. Only upon completion of the investigation by D.C.F. and subsequently the Office of Inspector General for D.J.J.(hereinafter referred to as O.I.G.), was a staff person allowed to return to all duties.

This Grand Jury finds that while processes were in place to address each incident as it occurred, D.J.J. and Premier did not adequately address the root causes, so as to reduce the quantity of incidents. Neither Premier nor D.J.J. pro-actively monitored the incidents for trends or other signs of problem areas which resulted in having to rely on the media to bring attention to the situation at F.I.G.

This Grand Jury finds three major areas of concern that directly affect the safety of both the girls and the staff at F.I.G. These include **staffing, staff training and behavior management** of the girls.

The consistent problem as voiced in testimony from all witnesses was the inadequate staffing at F.I.G. by Premier. Inadequate staffing often resulted in a domino effect leading to the following: increased number of lock-downs, cancellation of physical/outdoor activities, cancellation of educational classes, cancellation of various therapy sessions (group and individual), cancellation of volunteer programs, cancellation of special activities, pent-up levels of energy and frustration in the girls, increased violence and defiance by the girls resulting in more take-downs, potential physical and sexual abuse of the girls by the staff, increased abuse calls and subsequent investigations.

Inadequate staffing at F.I.G. by Premier also resulted in the following staff issues: high turnover rates, excessive overtime, poor morale, lack of respect for F.I.G. management and no time for staff training.

The second concern that also contributed to confusion and violence in this facility is the lack of sufficient training for each staff person.

Testimony revealed that staff were often placed on active duty with as little as one week of training. Instruction on how to safely execute physical take-downs, a procedure called Protective Action Response (hereinafter referred to as P.A.R.), was often not provided for four (4) to six (6) months after the staff person entered the dorm. This is in direct conflict with a special provision of Premier's contract requiring 120 hours of training (including forty (40) hours of P.A.R.) prior to a staff person taking active duty. This training requirement was clearly outlined in the bid process. D.J.J. failed to enforce their own contract requirements. Premier failed to provide the required training. This breakdown clearly resulted in inappropriate take-downs, as well as girls targeting the untrained staff person in an effort to manipulate them.

Staff training in working with girls with major mental health issues was totally inadequate. Premier's training did not include the necessary tools for staff to deal with the behaviors resulting from mental health issues or the girls' tremendous need for attention.

Training on ethics and professionalism for the staff was also lacking. This deficiency contributed to a negative peer culture among some of the staff, fueling coverups and inappropriate conduct.

Behavior management of the girls is the third area of operation that this Grand Jury finds contributed to the volatile environment at F.I.G.

Premier accepted this contract for approximately five (5) million dollars a year to incarcerate and treat female juvenile offenders with mental health issues. Over the last three (3) years, the behavior management systems that have been tried were modeled after male commitment programs with fewer mental health issues. Each year this portion of the facility was rated as failing. Many times the girls were out of control and the staff did not have the tools to effectively manage behavior that was often violent, manipulative and hopeless. Girls with little or no mental health issues were constantly mixed with those who

had serious mental health issues. Co-mingling caused major disruptions between the two groups.

This environment fostered the hopelessness of many of the girls in the facility. They felt there was nothing to gain from the program. They just "did their time." Promises by staff were often broken because of intervening disruptive behavior by a few who ruined it for others.

The Grand Jury recognizes that over the last few months a different behavior management system has been initiated. The number of incidents and abuse calls appear to have lessened. It is hoped that this decrease is a sign of success for the program. However, if behavior management is not brought under control by F.I.G., a new provider should be considered.

The Grand Jury finds that Premier has flexibility to spend additional funds to improve these problem areas at the cost of decreased profits. The financial records reviewed indicated Premier's profit margin is healthy enough to make these changes. Premier contracts for millions of dollars from the State of Florida to run a number of juvenile programs. This company must accept responsibility and comply with its contractual obligations. The status quo at F.I.G. is not sufficient to ensure the safety and well being of the girls and staff.

D.J.J. must also accept responsibility for improving these issues at F.I.G. in any area that Premier is not contractually liable.

In conclusion, this Grand Jury recommends that Premier increase staff at F.I.G. to ensure the safety of the girls and that all necessary services are provided. Further, Premier must comply with its contractual obligation to provide staff with 120 hours of training prior to direct contact with the girls. Premier must establish an effective behavior management plan that ensures that the girls are safe and controllable. It is only after these objectives are met that the girls will be able to benefit from all the services Premier is under contract to provide.

Further, D.J.J. must more actively monitor these three areas of concern, especially in areas of contractual obligations.

Everything must be done to ensure the safety of the girls and the staff.

GRAND JURY FINDINGS AND RECOMMENDATIONS

I. SELECTION PROCESS

First, the Grand Jury questioned why D.J.J. contracted with a private corporation to operate F.I.G. and how Premier was chosen for the contract. The Grand Jury finds the following facts from the testimony and evidence.

1. PRIVATIZATION OF JUVENILE JUSTICE COMMITMENT PROGRAMS

In the early 1990's, the State of Florida contracted with available private corporations to accommodate quick initialization of new residential programs to meet the needs of the Juvenile Justice commitment system.

Presently D.J.J. contracts with forty one (41) providers to run approximately 163 commitment facilities in this State. Of the forty one (41) providers contracting with D.J.J., nineteen (19) are non-profit, fifteen (15) are for-profit, and seven (7) are other governmental agencies.

The Grand Jury heard testimony and viewed reports on privatization. Based on the testimony heard, this Grand Jury finds the following to be true:

The bureaucracy and red tape required to start a new state-run commitment program took from 12-24 months to complete. The legislature responded to the tremendous need for more juvenile commitment beds but D.J.J. could not get these programs functioning in a timely manner. In the early 1990's the Legislature and D.J.J. determined that a private corporation had far greater flexibility and resources to bring programs on-line quickly.

Private providers were found to have a greater advantage over state- run programs in their ability to move budget money from different line items to accommodate changes in programming. State run facilities cannot move money from one budget line to another. This ability to move money easily gives a private provider the power to increase the number of positions and salaries when needed to ensure the safety and security of the juvenile offenders.

Additionally, a private provider has access to funds outside of the D.J.J. budget. When emergencies arise, the private provider may seek other funding sources to manage the crisis. This is not available to state run facilities.

Finally, the use of private providers to operate juvenile commitment programs is less costly to the State. Salaries account for a majority of the contracted dollars. A state-operated facility must ensure that all state employees receive the same basic pay scale and benefits. A private provider can offer a lesser pay scale and lesser benefits.

Although these issues reflect the advantages of privatization there are a number of disadvantages as well. First is the inability of D.J.J. to control hiring and firing within the programs. The D.J.J. regional directors can strongly recommend that certain employees be dismissed by the provider, but hold no authority to effect that change.

Additionally, D.J.J. has no direct control over the actual program development and how monies are spent. The contracts set minimum standards and give D.J.J. no authority to insist on changes such as higher pay rates or increases in staff.

Finally, a private provider is less accountable to the taxpayer. Once it receives the contracted dollars and contractual standards of service are met, D.J.J. is limited in holding the provider accountable for issues such as deficient staffing, escapes and failure to properly report incidents.

When situations arise that are not covered by contractual provision, D.J.J. has no authority to effectuate changes in such areas. The Grand Jury finds that where the contract does give authority, D.J.J. did not always follow through with ensuring provider compliance.

2. REQUEST FOR PROPOSAL DEVELOPMENT FOR F.I.G.

With a decision made that a private provider would be used to operate this new facility, D.J.J. proceeded to bid this project.

D.J.J. uses Requests for Proposals (hereinafter referred to as R.F.P.) to find private providers for each facility. Since this Maximum Risk Girls Program was the first in the State, there were no providers available who had successfully run such a program.

In 1999, a D.J.J. contract manager wrote the R.F.P. for this girls program. She researched other programs around the country, and utilized her gender specific expertise and the model from the Boys Maximum Risk Program. The RFP was reviewed in Tallahassee before being published.

Six providers entered bids. Those bids were scored by three separate individuals. There was no collaboration among the three individuals. The scores were sent to Tallahassee and were averaged together. The highest average score received the award. The award went to Ramsay Youth Services, Inc. (presently known as Premier Behavioral Solutions). Premier had already contracted with D.J.J. on a few other juvenile justice programs and had mental health hospitals in other states as well. The original contract was negotiated and executed in January 2000.

Considering this was a new program, the R.F.P. process appears well designed. The local D.J.J. contract management office created specific program requirements that were not found in other program contracts. These special requirements were included based on the type of girls they were to work with and the fact that this was the highest level of juvenile incarceration. One major requirement was that no staff take active duty without first receiving 120 hours of training**.** Although the R.F.P. and contract both required this training, compliance has been ignored by both D.J.J. and Premier.

II. ACCOUNTABILITY

The next area the Grand Jury questioned is whether D.J.J. adequately holds Premier accountable for services to the girls as well as the operation of the facility. There are three basic areas the Grand Jury evaluated for this determination: the contract, a peer review of services called Quality Assurance and the work of the Office of Inspector General (O.I.G.)

1. CONTRACT ISSUES

A. Contract Development: The contract for F.I.G. was created in the same manner as all other contracts for juvenile facilities. There are boilerplate clauses and clauses created specifically for F.I.G. The contract renewal process appears to be

automatic. The Grand Jury found no special incentives or disincentives added to this contract. There is no formal means to enforce compliance with all the contract clauses other than finding Premier in "breach of contract" and its removal as the provider. Premier is given too much latitude for lack of contract compliance. The Grand Jury finds evidence of this noncompliance with the following contract clauses:

> G.17.1 Basic Training Requirement
>
> "The provider shall ensure that prior to reporting for active duty, all direct care staff complete the 120-hour training for residential program personnel offered through the Departments' Professional Development Center. This includes Basic Training (Core Week 1), Use of Force Mechanical Restraint Training (Core Week 2) and Residential Services Training (Core Week 3). The Provider shall ensure that all direct care staff receive Use of Force certification and all case management staff complete training in performance planning within 30 days of hire."

Testimony, training files and monitoring reports clearly indicate that Premier has always failed to meet this contractual obligation. In fact, there was no testimony as to any time the facility was in compliance with this provision except the original staff on opening day. D.J.J. is clearly unconcerned with this noncompliance. Monitoring reports show more emphasis on the provider's Quality Assurance score in this area than on the actual contract. (Quality Assurance is a D.J.J. peer review system that scores various facets of program operation. Quality Assurance has a less stringent requirement for training staff.)

D.J.J. Assistant Secretary for Residential and Correctional Facilities justified this noncompliance. The fact that other contracted facilities are not required to ensure that staff are trained at this level prior to active duty was offered as an explanation. Further, the Assistant Secretary's position was to amend this contract and strike this clause. The Grand Jury finds this position to be completely unacceptable.

This Grand Jury finds that staff training is an integral part of maintaining order in F.I.G. Allowing staff to have direct contact with these girls without appropriate training creates an environment most conducive to the violence and confusion this jury has found to have existed in this facility.

H.12.2 Incident Reporting

"The Provider shall comply with the Department of Juvenile Justice, Inspector General's Statewide Incident Reporting Procedure. Failure to comply with this procedure could result in cancellation of the contract".

H.12.3 Client Risk Prevention

"The Provider and any subcontractors shall, in accordance with the client risk prevention system, report situations listed in the Inspector Generals's reports procedures now in effect or under such procedures as the Department subsequently issues."

The procedures described in this contract clause require that the facility allow the girls immediate access to the Child Abuse Hotline monitored by D.C.F. When that call is made, a D.C.F. protective investigator and a Palm Beach County Sheriff's deputy are to respond to the facility within twenty four (24) hours and speak directly to the girl making the abuse allegation. Once an abuse call is made the facility is obligated to complete an O.I.G. incident report in a timely manner. This information is to be reported to O.I.G. during working hours to receive a case number.

Testimony and review of hundreds of reports revealed a small percentage of incidents with missing or nonexistent O.I.G. reports. However, one specific case of a broken arm that occurred in 2002 was only revealed through reports to the Child Abuse Hotline. The D.C.F. abuse report did not include details of the girl's allegation that staff broke her arm. Because the girl was eighteen (18) years old at the time, D.C.F. did not have the authority to investigate this matter. In this case, no O.I.G. incident report could be located, nor any number assigned proving an incident report existed. No one looked into the cause of her injury. No witnesses could testify as to knowledge of this incident.

Additionally, the Grand Jury found another broken arm incident that occurred in July 2003. Contrary to O.I.G. reporting procedures required by this contract, the incident was not reported for seven days. There was no system for D.J.J. to monitor these situations and track these reports.

The Grand Jury is troubled that the provider is able to violate contractual clauses and must only submit and successfully complete a corrective action plan to maintain compliance. Once they complete this process, there is no penalty to ensure it does not happen again. The provider can repeatedly fail to comply with such provisions and simply correct them when caught.

D.J.J. is willing to accept noncompliance with some contractual clauses in an effort to ensure that these facilities continue to function. The decision to close a facility and remove of a number of beds from our juvenile justice system weighs heavily on D.J.J. D.J.J. may have waived these provisions by the acceptance of this noncompliance. Testimony further revealed that acceptance of noncompliance was a common practice for D.J.J. and private providers. The Grand Jury does acknowledge one exception to this practice. The Southern Regional Director has recently closed a commitment facility for not meeting its contractual obligation to safeguard against escapes.

B. Incentive/Disincentive: This contract contains no special incentive for Premier to provide services above the minimum requirement. The girls being confined in this program often require far more services than any other juvenile offenders in the system. Incentives for issues such as improved staff training and decreased turnover rates are especially important in this program. These areas affect the F.I.G. environment in a far greater degree than any other juvenile commitment facility. The use of incentives would foster a higher degree of care for these offenders. Also, this contract contains no disincentive. There is no monetary cost for being out of compliance with the contract. The lack of such a disincentive allows the provider to be less accountable to D.J.J. on issues such as failure to report incidents, escapes or failure to maintain appropriate staffing.

C. Contract Renewal: Contract renewal for this program appears to have been relatively automatic. Premier remained out of compliance with the training and behavior management contract clauses for years. Key learnings from prior years should be incorporated in the contract renewal process to improve operational standards. Renewal should also include any recent changes in policies and procedures of D.J.J. and D.C.F. An

example of this need to update contracts is the provision requiring "Use of Force" training instead of the current "Protective Action Response" training that is in practice.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF CONTRACTUAL ISSUES:

- The D.J.J. contract attorney must review the contract for all areas where D.J.J. has waived or is estopped from enforcing full compliance. Notice must be given to the provider that as of July 1, 2004 all waivers shall cease and noncompliance shall result in contract default.

- A yearly contract compliance audit should be done by the D.J.J. Regional office with the assistance of its attorney.

- All contracts should include a page for explanation of special provisions. This will ensure that personnel over the years understand the reasoning behind such provisions when deciding whether to allow modifications.

- Renewal on contracts should consider the program's performance, and the provider's ability and commitment to follow all required policies and procedures set forth by D.J.J. This evaluation should set standards that must be met before the provider will be considered for contract renewal. D.J.J. must take the initiative to review the contracts in light of changes in outside agencies, such as the court, law enforcement and D.C.F., that directly effect provisions of the contract.

- All contracts must carry provisions that allow D.J.J. to seek remuneration for failure to comply with special provisions. These areas of concern would include failure to report incidents, escapes, destruction of documents, failure to train staff fully, failure to maintain appropriate staffing and consistently low scores in its Quality Assurance reviews.

- All contracts must provide for a bonus incentive for the provider when it attains full compliance with the contract and achieves "commendable" or "excellent" ratings in its Quality Assurance reviews. Additional measurements can be determined by the parties to reward excellent programming.

- All contracts must retain a percentage of the contract dollars to be held in escrow for either incentive bonuses or retention of funds for noncompliance. Alternatively, D.J.J. should request legislative authority to create a bonus pool for providers who excel in services to these juveniles.

- ! All contracts should contain a clause stating that no Quality Assurance score can override compliance with a contractual provision.

2. MONITORING OF THE CONTRACT

D.J.J. has employees who are responsible for monitoring the programs and contract compliance. Palm Beach County area programs fall within the D.J.J. Southern Region of Juvenile Residential and Correctional facilities. In the last few years the staffing of the Southern Regional office has been reduced from eight (8) contract monitors to six (6) due to budget cuts. These six (6) contract monitors are responsible for the eighteen (18) commitment programs located in the Southern region. Testimony established that one of the responsibilities of the monitors is to approve and monitor corrective action plans in all areas where the program has scored poorly in its Quality Assurance review. Additionally, they must visit once a month to monitor certain areas of contract compliance, and occasionally investigate incident reports from the facility. The Grand Jury finds this level of contact to be inadequate to ensure accountability of the program.

Specific to F.I.G., the former contract monitor's case file did not substantiate even this basic schedule of visits. This sparse contact led to D.J.J. having little knowledge of or impact on the escalating problems within F.I.G. There was some documentation of reports to an immediate supervisor concerning the training issues at this facility, but even that information did not result in any improvement of the situation. Unannounced spot checks were rare. Corrective action plans appeared too general and vague.

The newly assigned contract monitor has taken a more aggressive approach to ensure that D.J.J.'s policies and procedures are being followed by the program in addition to contract compliance. The contract monitor presently inspects the facility at least once a week, and monitors all incident reports on a daily basis. This contract monitor reports all findings to a number of supervisors to ensure that D.J.J. administration is fully informed of the issues at F.I.G.

This monitor and the regional director recently rejected the corrective action plan for behavior management submitted by the facility in August 2003. D.J.J. required more specifics including measurable outcomes to prove acceptable performance.

Numerous witnesses testified that any conflicts between D.J.J. commitment standards, Quality Assurance requirements, and the contract must be resolved in favor of the contractual agreement. No one could testify to actual knowledge or enforcement of the contractual provision requiring Premier to ensure that all staff receive 120 hours of training prior to taking active duty. This Grand Jury finds that this lack of training impacts negatively on the operation of the facility and the safety of the girls and staff. D.J.J. through its contract monitor and supervisors is responsible for ensuring that this and all other contract provisions are followed by the provider.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF CONTRACT MONITORING:

- Contract monitors should conduct periodic spot checks of facilities without notice to the provider. All contracts should contain this provision.

- D.J.J. should mandate a minimum monthly report to the Regional Director from the monitor reflecting all issues, trends and concerns. In this situation, surplus communication is far better than waiting for a major problem to occur before reporting to the Director.

- Contract monitors should fully understand and enforce the contract. It is inappropriate for D.J.J. to allow its monitors to make assumptions that certain contractual provisions are no longer necessary for compliance simply because D.J.J. correctional standards or Quality Assurance measures require less from the provider.

- Noncompliance must be addressed in a documented plan rectifying the failure. If the failure is not corrected in the time set forth in the plan, or if the noncompliance continues anytime after that period, it must be dealt with as a breach of contract.

3. QUALITY ASSURANCE

Another tool of accountability is the D.J.J. peer review system for evaluating all facets of a juvenile commitment program. This is called Quality Assurance. The Quality Assurance standards are created in Tallahassee and are uniform around the state. Teams of peer reviewers give a facility thirty (30) days notice that they will be spending a week at

the facility to evaluate and score various areas of the facility including: security, physical plant, mental health, behavior management and others. The Quality Assurance evaluations are done on a yearly basis. These scores fall into the following ranges: Failed, Minimal, Acceptable, Commendable and Excellent. Any score that is less than acceptable results in the contract monitor requiring, approving and monitoring a corrective action plan by the facility to bring them into compliance.

Documents revealed that F.I.G. has had three Quality Assurance evaluations. The 2001 evaluation's overall score placed them in the "Minimal Performance" range, with a failure in the "Behavior Management" category. The 2002 evaluation's overall score placed them in the "Acceptable" range by only 1 point, with repeated failure in "Behavior Management" and failure in "Training and Staff Development." The 2003 evaluation's overall score placed F.I.G. strongly in the "Acceptable" range, though once again failing "Behavior Management". Each year a different team of reviewers scored the program. A comparison of these reviews revealed a problem with the subjective nature of this process. Certain areas were scored higher or lower than the previous year even though that program area and process were identical from year to year. In the three years of evaluations no peer reviewer ever returned for the subsequent year's evaluation nor does the process emphasize any comparisons to prior scores.

This Grand Jury is concerned that some Quality Assurance standards are in conflict with the present contract for F.I.G. The Grand Jury finds that the original contract mandated that staff receive 120 hours of training prior to taking their position at the facility. The Quality Assurance standard only requires this training to take place within the first six months of employment. This conflict resulted in Premier placing untrained staff with the girls simply because other D.J.J. contractual programs did. Though uniformity is often well founded, in this situation, D.J.J. contract specialists made a specific decision that the standard policies of other programs were not going to be sufficient for F.I.G. The Quality Assurance standard allowed Premier to receive a "commendable" evaluation for training despite being out of compliance with this provision of the contract.

D.J.J. and providers cannot presume that having a passing grade in Quality Assurance ensures contract compliance. Quality Assurance is a statutorily mandated

process utilized by D.J.J. for objective assessment of program operation, management, governance and service delivery based on established standards. It is not intended to assess specific contract compliance.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF QUALITY ASSURANCE:

- One person from the previous year's review team must be assigned to review this program each subsequent year. This will help eliminate the inconsistencies between the scores from year to year for the same procedures and practices.

- A passing score in a Quality Assurance review must never be used by the D.J.J. contract monitor to assume contract compliance.

- Quality Assurance standards must not be in conflict with contract provisions. The contract requires Premier to ensure that staff receive 120 hours of training prior to taking their positions. While no corrective action plan may be required by Quality Assurance standards, one is mandated for contract noncompliance.

- Quality Assurance peer reviewers should read the previous year's report and target areas that had previously been scored low. In addition, reviewers must address inconsistencies with prior scores before leaving the facility.

4. D.J.J. OFFICE OF INSPECTOR GENERAL

Another area concerning the effectiveness of D.J.J. to oversee a private provider and hold it accountable, centers around D.J.J.'s ability to investigate complaints against state or contracted employees. These duties fall under the auspices of the Office of Inspector General.

O.I.G. is a division of D.J.J. responsible for investigating complaints from juvenile offenders against D.J.J. employees or contract employees. As with the contract monitors in the regional offices, this unit has also suffered a loss of personnel due to budget cuts.

A hotline is established in this office to handle all calls reporting incidents such as allegations of abuse, inappropriate relationships between staff and juveniles, escapes,

crimes occurring within a facility, riots etc. Unfortunately, O.I.G. personnel are only available to take these calls and assign tracking numbers to the incident on Monday-Friday 8:00am-5:00pm. An on-duty investigator is on-call after hours and weekends to receive an informal report of the incident and make decisions as to who needs to be informed. There is no assignment of a tracking number by this investigator. This must be done by another call from the facility to O.I.G. during business hours. A review of records revealed a problem that some hand written reports from F.I.G. had never been logged with O.I.G. As a result, there was no D.J.J. investigation into these matters. Further, no information concerning these reports was located in the O.I.G. database.

The database that is used to collect this information can generate reports on trends concerning specific facilities, regions, types of crimes, etc. O.I.G. does not publish such reports nor work with this trend information. However, the regional commitment offices now have access to create and publish such reports to assist in monitoring.

O.I.G. had to re-evaluate which cases it can reasonably investigate based on cuts in personnel. Many incidents are now being sent back to the regional D.J.J. office to have the contract monitor investigate the allegation instead of a trained O.I.G. investigator. Further, some incidents are being withheld from assignment until D.C.F. has concluded its findings. This process itself can take 30-60 days. If D.C.F. determines the allegation is "founded", an investigator from O.I.G. is assigned to work the case. This delay results in investigators coming into a case too late to obtain accurate testimony and evidence. Staff have often been fired or moved out of the area. The juvenile may have since made decisions not to cooperate for whatever reason and witnesses have either changed stories or lost memories.

O.I.G. does not have the ability to compel witnesses to give statements. It has no subpoena powers. Its investigations are comprised of voluntary interviews and review of records and logs.

If an investigator is assigned an on-site investigation, it often takes thirty (30) days to complete the investigation. In addition, it takes another sixty (60) days for the Inspector General to make a final ruling on the investigation. This delay leaves programs with personnel on suspension for months disrupting the staffing patterns of the facility, and causing staff resignations. An example of the untimely response time of O.I.G. is found in

two recent cases of girls who were involved in physical take-downs that resulted in broken arms. One case that occurred on July 6, 2003 was completed on November 3, 2003. Another case that occurred on July 16, 2003 was completed on November 6, 2003.

Another responsibility of O.I.G. is to complete State and Federal criminal record checks on D.J.J. and contracted employees working with juveniles. A conflict in testimony revealed that although O.I.G.'s goal is to run prompt record checks, the checks often took weeks to complete and be returned to the facility. In the interim, the employee had been working directly with juveniles.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF THE OFFICE OF INSPECTOR GENERAL:

- F.I.G. procedures must include a requirement that every facility institute an internal numbering process for each P.A.R. report, incident report and confinement report in order to ensure that no report can be destroyed without a paper trail.

- The number of O.I.G. investigators must be increased to ensure that they respond more timely to the facility investigations. O.I.G. should finalize all reports within ninety (90) days. If additional time is needed for further investigation only, this must be reported to both the Secretary of D.J.J. and the Regional Director. Such reports should be every thirty (30) days until the report is finalized.

- These investigators should also be given the ability to compel testimony of all witnesses with the exception of the potential perpetrator.

- O.I.G. must be available twenty four (24) hours, seven (7) days a week to accept reports and assign report numbers. Delayed calls for assignment of a case number facilitates reports being "lost" or altered. O.I.G. should look into the feasability of sharing state personnel who work after hours to handle the acceptance and numbering.

- All Regional Directors should have the capability and responsibility to create reports from the O.I.G. database. These reports should focus on the types of crimes in the facilities, the types of calls, results of investigations and number of calls per facility. These directors should use this data to work with the providers in creating preventive measures to address negative trends and ultimately ensure the safety of the juvenile offenders and staff.

- Background checks for new employees working with juvenile offenders must be completed in a timely manner.

5. INCIDENT INVESTIGATIONS

Investigations of incidents in juvenile justice facilities often result in as many as three different agencies sending representatives to the facility to look into a juvenile's allegation of abuse. When a juvenile calls the abuse hotline, a protective investigator from D.C.F. and a law enforcement officer must appear at the facility to investigate the incident. D.C.F. looks into the safety of the juvenile. Law enforcement looks into whether there is sufficient evidence to charge anyone with a criminal act. O.I.G. investigates whether the employees behavior violated D.J.J. policy and procedure affecting the juvenile's safety and well-being. Each investigator interviews the complaining juvenile, takes statements from witnesses and reviews security tapes and other physical evidence. This Grand Jury finds that a substantiated or founded determination of any allegation results in immediate intervention by management and usually termination of the offending employee. D.J.J. receives copies of all investigations and uses these as a tool to monitor facilities.

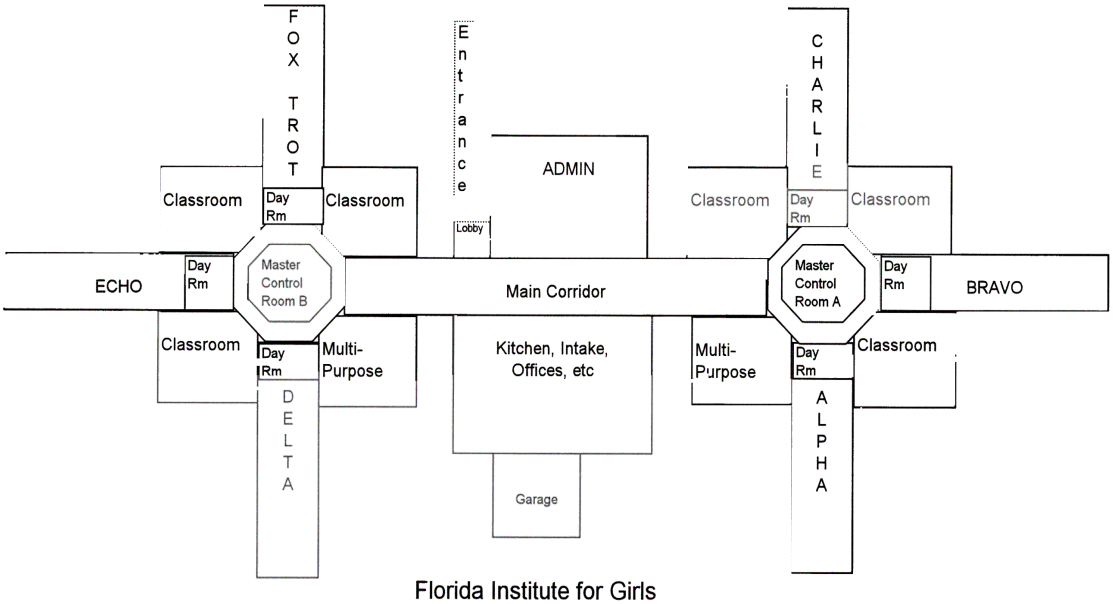
III. PROGRAM OPERATION

This Grand Jury next reviewed the actual operation of the F.I.G. facility by Premier.

Though the Grand Jury was not able to tour the facility based on statutory mandates of secrecy, it was able to review video tapes, photographs and testimony. The Grand Jury concludes that the physical plant is functional and appropriate for this level of incarceration. However, certain areas of this facility were found to be inadequate or improperly staffed.

1. FACILITY ISSUES:

The diagram printed below is of the physical plant at F.I.G.



Florida Institute for Girls

A. Security Cameras

The original camera system was inadequate to meet the safety needs of the girls and staff. There were numerous blind spots that were well known to all. All cameras were in plain view with no audio.

This system involved the use of VCR tapes to record the various camera views. Testimony revealed that the cameras were often broken for weeks at a time. Even when the equipment functioned, the facility often failed to secure the tapes for a reasonable time which resulted in tapes being "lost" or recorded over.

A perfect example of this negligent practice is in the criminal case of Jason Crawford.

In September of 2001, Jason Crawford, a 24-year-old male, employed at F.I.G. as a youth care worker, sexually assaulted a minor juvenile offender. As in many cases of sexual abuse, the victim delayed reporting for several days. Statements obtained by the detective from the Palm Beach County Sheriff's Office showed that while in the dormitory, Crawford approached the girl's room and made inappropriate sexual comments. Approximately a week later, Crawford again approached the same girl at the door of her room and asked to see "down there". He then reached into the cell and touched the girl's vaginal area. On both occasions, Crawford was not accompanied by a female youth care worker, as required by F.I.G. standard operating procedures.

During the detective's investigation, he personally verified that the witness in the cell on the other side of the hall was in a position to observe Crawford's actions as she stated. The detective also sought physical evidence in the form of the security surveillance video, but was informed that this was not available as the camera system was not working properly at that time.

Jason Crawford was arrested and the State Attorney's Office prosecuted him for Lewd Molestation. During the prosecution process, witnesses began to change their testimony. The case became difficult to prove due to the inability to corroborate witness statements with physical evidence, i.e. the VCR tapes from the camera in the dorm. Crawford plead guilty to Aggravated Assault with the Intent to Commit a Felony, a third degree felony, and was placed on probation with conditions specifically designed to ensure the safety of other minors. At the time of his arrest, Crawford was suspended; his employment was ultimately terminated.

This Grand Jury finds that O.I.G. did substantiate that the facility violated D.J.J. policy by leaving male staff alone in the dorms. Further, the evidence substantiated that F.I.G. management failed in its procedures concerning the functionality of the cameras. O.I.G. recommended the facility create a corrective action plan.

In further reviewing the tapes, the lack of audio capability hampers any investigation of either criminal acts or violations of facility policy. In the case cited above,

an audio tape of any conversation between Jason Crawford and the minor victim would have corroborated the victim's testimony and enhanced the ability to secure a conviction as charged.

In October 2002, a digital camera system was installed pursuant to a recommendation of the Palm Beach County Sheriff's Office (hereinafter referred to as P.B.S.O.). In addition to the change from VCR to digital, more cameras were added to alleviate the numerous blind spots within the dorms.

This Grand Jury reviewed several digital records of juvenile take-downs. The new system while better than the previous system still has areas that are not recorded by the cameras. The digital picture is not always clear enough to determine what happened. An example of a blind spot appears to be the area where the day room connects into the hallway to the rooms. In some dorms this area is clearly visible and in other dorms this area is totally out of camera range. This was found on a number of security tapes from 2003. It is not clear whether some of the cameras are simply out of alignment or positioned incorrectly.

Testimony revealed a lack of training and confusion on the capabilities of the camera system. This may have resulted in the recorded discs not properly displaying the events under investigation. However, the placement or alignment of the cameras may also contribute to this problem.

This problem was clearly defined in the case of a broken arm in July 2003. The Grand Jury reviewed the digital disc and most of the incident was not captured, due to the number and placement of the cameras. The disc, as recorded, did not provide the software or capability to "zoom in" on the actual event. There was no other camera view that captured the take-down.

D.J.J. has recently taken advantage of the new digital cameras ability to broadcast to remote sites. The regional director and contract monitor both have access at their desks, to monitor security tapes in real time, daily from F.I.G.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF SECURITY CAMERAS:

- Management must review the security camera recordings to eliminate blind spots in the dorms and intake area. Cameras with overlapping views should be added in any area that the present system cannot cover. Adjustments to existing cameras should be made to further eliminate blind spots.

- Examine the feasability of adding audio recording capabilities to the dorm areas. Alternatively, research hand held radios systems that may allow for continuous audio feed to a specific recording system.

- Provide more extensive training to Master Control staff on the camera recording system and enhancements including "zoom", that may be necessary for future investigations.

B. Master Control

Another area that directly impacts the investigation of allegations made by the girls or staff is the staffing and operation of the Master Control Rooms.

F.I.G. has two master control rooms. These rooms sit as the hubs for three (3) dorms each. The master control rooms contain camera monitors and windows covering three dorms each and all corresponding hallways and classrooms.

Testimony showed that only one person is stationed in each master control room. His/her responsibilities and duties require the monitoring of thirty-two (32) cameras, call boxes from fifty (50) cells, electronic door operation and radio dispatch. These major duties are to be completed in addition to paperwork, which includes the logging of any movement of girls or the locking-down of any dorm, and answering the telephone. This Grand Jury finds that one person can give only minimal attention to these cameras.

Management does not provide for regular necessary breaks away from these cameras in order to ensure an alert staff. Lunch breaks are often required to be taken at the desk because of minimal staffing for coverage.

Video tapes of daily events in the dorms were stored in Master Control. Numerous people had access to these tapes which resulted in tapes being lost, or recorded over on a

number of occasions. This Grand Jury finds this destruction of evidence hampered possible criminal investigations.

In the summer of 2002, officers from P.B.S.O. met with F.I.G. and D.J.J. officials to create a security plan that was designed to protect these tapes from further tampering. The facility immediately put this procedure in place.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF THE MASTER CONTROL ROOM :

- ! This area must always be staffed by two persons. The duties are too numerous for one person to manage especially during altercations.
- ! Log entries should be uniform in use of abbreviations and data entered.

C. Disciplinary Confinement Areas

A deficiency of the facility is the location and the use of the disciplinary confinement rooms. The disciplinary confinement rooms for this facility are located in the intake portion of the building well away from the dorms. Disciplinary confinement requires observation and ten (10) minute checks by staff. To use the disciplinary confinement rooms, the facility management often pulled staff from duty posts in the dorms instead of providing the appropriate number of staff for both areas. This resulted in the need to "lock-down" the other girls in the dorms when staff was short.

The evidence established that staff assigned to monitor these rooms were negligent in maintaining appropriate monitoring logs and reports. There are incidents of staff filling out the 10 minute check logs in advance, and then not performing the mandatory checks on the confined girl.

F.I.G. management has restricted the use of these disciplinary confinement rooms over the last year based in part on these issues. Consequently, there have been further complaints by the girls that restricting the use of these disciplinary confinement rooms leaves the uncontrollable offender in the dorm with the girls who are trying to achieve their daily goals. This disrupts the day for everyone.

There is no padded confinement area or "soft room" to assist staff with calming a girl and ensuring her physical safety. Testimony revealed that such rooms are used in mental health facilities and recommended by professionals.

Behavior Modification Units are authorized by D.J.J. for offenders who are chronically beyond the control of the program. However, there are certain guidelines that must be followed. This unit allows for the separation of uncontrollable girls from those trying to work within the program. No such unit was created by prior management. The present management created this unit in a 16-bed dorm. The girls were housed here for a period of 14-30 days. This unit has already been closed down by present management to allow for the influx of new girls being assigned to the program.

Presently, the only dorm area available for such redirection will be the newly designated "orientation" dorm. In that scenario the program will be mixing girls who are presently out of control with girls who are new to the program. The Grand Jury questions the appropriateness of combining these girls. This Grand Jury finds that increased staffing in this area is necessary to ensure the safety of the girls and the staff in such an environment. Exposing girls new to the program with the worst offenders in the facility immediately exposes girls to objectionable and harmful behavior. Creating such an injurious environment is contrary to the goals of F.I.G.

THE GRAND JURY RECOMMENDS THE FOLLOWING CONCERNING THE USE OF DISCIPLINARY CONFINEMENT:

- Premier must ensure that an adequate number of rooms can be used for disciplinary confinement. Adequate additional staff is needed to use the disciplinary confinement rooms in the intake area. If the "orientation dorm" is used, enough staff must be assigned to handle the disruptive behavior and protect the girls. F.I.G. cannot function without a tool of disciplinary confinement.

- One disciplinary confinement room should be redesigned as a padded/soft room as used in mental health facilities.

- **!** A punch clock or other computerized system should be installed in this area to ensure that all safety checks on girls in disciplinary confinement are completed within the mandated time periods.

2. STAFF ISSUES

A. Inadequate staffing

Staffing issues are a recurring area of concern for this Grand Jury. The following are facts determined through testimony and review of documents.

This Grand Jury finds that F.I.G. consistently did not meet its required staffing ratio of one (1) adult for every eight (8) girls. This inadequate staffing resulted in locking down a number of girls to maintain the ratio, cancelling classes and therapy sessions, cancelling community access sessions, cancelling recreation and cancelling visitation. This caused rebellious behavior by the girls. Numerous incidents of battery on staff and other girls were directly related to these lock-downs and cancellations.

An example of how these lock-downs caused increased aggression in the girls is the case of another girl with a broken arm.

In July of 2003, a juvenile offender suffered a broken arm. The testimony and surveillance video revealed that the incident began in the day room of the Bravo dormitory. The girl and several other juvenile offenders were demonstrating disruptive behavior. They were refusing repeated commands to go to their respective rooms. The girls had spent almost the entire day locked down due to staff shortages. They were allowed out of their rooms for a short period of time and then ordered back into lock-down, not for misbehavior but for staff shortage again. Needing additional staff, youth care worker "A" was advised to report to Bravo dormitory to assist in securing the situation.

After most of the juvenile offenders calmed down and complied with the directions to return to their rooms, youth care workers "A" and "B" returned to the day room to escort the girl to her room. The girl began running from side to side behind a table, and when touched by youth care worker "A" became aggressive, pushing and swinging toward staff, then grabbing the table to resist. The girl tripped causing everyone to fall to the floor. During the continued struggle on the floor, the girls's arm was fractured.

This Grand Jury finds that despite numerous verbal prompts the girl was a willful, rebellious and aggressive participant in this incident. Premier reacted to this situation by terminating both youth care workers. Youth Care Worker "A" was terminated for excessive use of force. Youth care worker "B" was terminated for assisting "A" by using P.A.R. techniques without being certified to do so.

This Grand Jury finds that this incident amplifies the root cause of inadequate training and staff shortages. There were not enough staff on duty to alleviate locking down the girls all day. Staff were placed on active duty without being certified to use P.A.R. techniques for take-downs. F.I.G. management's response was to blame staff.

Further, this Grand Jury finds that the practice of locking down the girls for periods of time and cancelling all daily activities because of staff shortages is inexcusable, violates the contract and clearly contributes to the violence in the facility. A continuation of this practice should result in the immediate dismissal of Premier as the provider for F.I.G.

The inadequate staffing by Premier also contributed to inappropriate staff behavior. Male staff are prohibited from being alone with a girl and entering a girl's room without a female staff in attendance. However, staff shortages contributed to circumstances allowing certain male staff to violate this policy resulting in allegations of inappropriate touching.

Inadequate staffing also contributed to a protective culture among some of the staff, that fostered coverups and non-reporting of inappropriate behavior in at least one case. O.I.G. reports substantiated this behavior by staff and recommended termination of a number of staff.

Inadequate staffing by Premier also contributed to an increased level of aggression between staff and girls. An appropriate technique in de-escalation of crisis situations is to have the original staff person who is in conflict with the girl remove himself or herself from the area and allow other staff to de-escalate the girl's behavior. That was rarely possible at F.I.G. because there were not enough personnel immediately available to take over.

Inadequate staffing is a result of paying only $8.50/hour for a hazardous job that requires direct care of girls with mental health issues. The ability to attract and retain

youth care workers with the necessary skill and maturity to deal with this type of offender is virtually impossible at the current pay scale. Palm Beach County has a very high cost of living standard, and keeping employees often requires pay incentives.

Over the last three (3) years this program has lost over 408 employees through resignation or termination. In the first year of operation the program lost 90% of its original employees.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF STAFFING:

- Premier must ensure that the program is adequately staffed to cover breaks, confinement, training, absenteeism and delivery of all services to the girls. Appropriate staffing requires the necessary hiring and training of new staff, and also the retention of present staff. Increases to the pay scale for direct care staff such as youth care workers I and II and shift supervisors are needed. In addition, pay raises should be given consistent with training and experience to help reduce staff turnover.

- Staffing must be maintained to ensure that all the operating procedures focused on male staff's contact with the girls is followed at all times. Premier should further require all male staff to ask for camera checks when walking through the dorms or escorting a girl.

- Premier must immediately desist in the practice of locking-down the girls because of inadequate staffing. D.J.J. is responsible for monitoring this and must terminate this contract if Premier persists in this.

B. Staff Safety

Staff safety is a consistent problem at F.I.G. Lack of training and inadequate staffing contribute greatly to this. In addition, the mental health issues of some of these girls are reflected in their acting out in violence and the manipulation of incidents. A number of these girls will do whatever it takes to be touched by the male staff, including battery or defiance of all verbal commands in order to be taken down.

Many of these girls have suffered earlier sexual or physical abuse. They have emotional and mental health issues that often result in the manipulation and attempted seduction of the male staff. To some girls it is a game to "case up" the male staff by lying about sexual involvement. If a girl believes a male staff is not giving her enough attention, she can "punish" him by calling the abuse line and making numerous false allegations of sexual abuse. The girls know that this will automatically require that male staff be removed from the dorm and often be suspended until completion of an investigation.

A clear example of this type of manipulation are the abuse complaints that are made against certain male staff who were not on duty on the day the acts were alleged to have happened.

Female staff experience other safety issues. Female staff are often compromised by the difference in size between staff and some of these offenders. The girls often will ignored the female staff person and are not intimidated by her authority.

The offenders know which staff are allowed to initiate take-downs and which staff are still under training. Those under training cannot touch the girl unless it is to assist a trained staff person. Even when they assist, they are not allowed to use P.A.R. techniques. Premier's placement of staff on active duty without the appropriate certification of training, places that staff person and those with whom he or she works in an unsafe environment. It puts them at a disadvantage to do their job and react appropriately to the girls' behavior. This also places the staff person in a position of choosing whether to help another staff or possibly be fired if their help is considered inappropriate for someone who is not certified.

Further, the Grand Jury finds that the use of open radio transmissions places the staff at a disadvantage because the girls can hear every transmission and take advantage of the situation.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF STAFF SAFETY:

- Staff must be vigilant in following policy and procedures to protect the girls and themselves.

- All staff must be trained and have taken the P.A.R. certification test prior to working with the girls. The uncertified staff person, should never be counted in the staff/client ratio.

C. Staff Culture

The culture of some staff was to protect each other, fostering coverups and unprofessional conduct between staff and girls.

Some incident reports reflect this attitude of silence when confronted with possible wrongdoing by another staff person. An example of how dangerous this became is shown in the criminal case of Larry Curry.

In March of 2002, Larry Curry, a 29 year old male, was employed at F.I.G. as a youth care worker. In this position, he came into contact with, and had unlawful sexual activity with two juvenile offenders, one of which was a minor. An investigation by P.B.S.O. revealed that Larry Curry escorted one minor from the recreational yard into a staff bathroom through a door that had been previously propped open. No female staff member was involved in the escort and the exterior door indicator light appeared to have been ignored by master control. Once in the bathroom, Curry proceeded to have unlawful sexual intercourse with the minor.

On that same day, Larry Curry had a second unlawful sexual encounter with another juvenile offender. Again, Curry was able to escort the girl to the same staff bathroom, without another staff member being present and without the appropriate call to master control. Although secured doors were unlocked by Curry, these openings were never questioned by master control.

Further investigation revealed that five other staff persons were told that this incident of sexual abuse had occurred. None of the five reported the allegations to F.I.G. management.

During the detective's investigation, another facility employee testified that he had entered the bathroom and found a condom wrapper in the trash on the same day of the assault. Unfortunately, this evidence was not preserved for law enforcement. Further, the

detective's review of the security video showed it to be of no evidentiary value due to poor clarity and the camera angle did not allow a view of the entrance of the staff bathroom.

Larry Curry was arrested and prosecuted by the State Attorney's Office. During the prosecution, several witnesses became uncooperative and the decision was made to settle the case without trial. Curry plead guilty to two counts of Sexual Misconduct with a Juvenile Offender, both second degree felonies, and was placed on probation with conditions specifically designed to ensure the safety of other minors. Curry evaded a sexual offender label because the crime of Sexual Misconduct with a Juvenile Offender has not been so designated by the legislature. At the time of his arrest, Curry was suspended; his employment was later terminated.

This Grand Jury finds that in the above criminal incident, master control did not alert management that the door had been propped open and staff did not alert management that Curry had just escorted a girl out of camera view without the assistance of a female staff person. The O.I.G. substantiated this cover-up and recommended the suspension of four youth care workers and the termination of one other in addition to Larry Curry.

F.I.G.'s new management has taken steps to address this negative culture among some staff. It has increased communication with staff, instituted tighter security procedures and terminated some employees. This Grand Jury finds that these steps are a start, but more work will be needed to better protect the girls from this type of behavior.

Testimony from girls, staff and management confirmed that this negative staff culture did not affect all staff. This Grand Jury finds that there are a number of very dedicated, hard working staff at F.I.G. However, the behavior of a few, overshadows the good work of the others.

The Grand Jury has reviewed evidence and testimony concerning Chief of Security, Shirley Jones and her affect on the negative culture within F.I.G. The following facts were found by the Grand Jury:

> 1. Security video tapes were destroyed on at least 6-7 occasions. After the second incident of destruction, as Chief of Security, Ms. Jones took no steps to guard the tapes from future destruction. Once Ms. Jones was aware of the destruction of tapes, it was her responsibility as Chief of Security to act and ensure the preservation

of such security tapes by instituting appropriate measures. She chose not to act and did nothing. This destruction continued a number of times and still nothing was done. Only after P.B.S.O. complained of this destruction of evidence and became involved were any steps taken to ensure the integrity and conservation of these tapes. This Grand Jury finds that Ms. Jones' lack of performance was completely ineffective as Chief of Security. Further, such dereliction of duties by Ms. Jones was counter productive and destructive to the security of the facility.

2. Testimony from witnesses established that Ms. Jones solicited three girls to lie about staff. The girls were threatened with an extension of their release date if they did not cooperate. Such abuse of authority by Ms. Jones was injurious to the girls. By her example, she was cultivating dishonest behavior.

3. A review of training records indicates that although Chief of Security, Shirley Jones was often in direct contact with the girls and staff, she had not undergone P.A.R. training and certification until a few months ago. As Chief of Security, Ms. Jones was in a position to offer opinions as to whether staff participated appropriately in a take-down. However, Ms. Jones had not been trained in this area, though it was continually available to her. A further review of incident reports indicated that Ms. Jones also assisted staff in handling disruptive girls, but she was not certified to do so.

4. Testimony revealed continual problems and distrust between staff and Ms. Jones. Prior management had removed Shirley Jones from her position as Chief of Security. However, she was reinstated as Chief of Security by the new management with no apparent conversation with prior management as to why she had been removed from this position.

5. An evaluation of the testimony of Ms. Jones against the entire evidence before this Grand Jury established that some of her testimony was found not to be credible.

This Grand Jury finds that someone in the position of Chief of Security at F.I.G. should set a professional example for girls and staff. This person should be trained better than any other and trusted implicitly. A Chief of Security should know how to manage people. Additionally, this person should ensure that all security tapes and camera systems are safeguarded. The Grand Jury finds that Ms. Jones is not suitable for this position at F.I.G.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF STAFF CULTURE:

- A policy and procedure must be developed that requires all external door openings to be called into master control and logged.

- All male staff must request a camera check whenever they escort a girl from the recreation yard to the dorm without a female staff person.

- Management must use training and communication or dismissal to break this negative culture. Silence in F.I.G. puts the girls at risk of abuse. Further, sexual misconduct within a juvenile facility must be stopped. The Grand Jury recommends that the legislature include this crime in the list of those that result in a sexual offender designation.

- Ms. Jones must not be retained in her position as Chief of Security or any other position at F.I.G. As an employee of Premier she may be better suited for another position in a different facility.

D. Staff Training:

Staff training is a paramount interest of this Grand Jury. Based on the evidence presented and the testimony of numerous persons, the Grand Jury finds that lack of timely and appropriate staff training was a major contributor to the problems at F.I.G.

For example, there was a case of a girl who was complaining to one staff person about her snack and repeatedly refused to return to her room. Another staff person intervened and gave her another verbal prompt which was refused again. That staff executed a custodial touch in an attempt to escort her to her room. The girl swung around and struck the staff person who was trying to escort her. The girl was then taken down to the floor by the staff and received a nickel-sized bruise to the back of her head. The girl called the O.I.G. hotline and complained of excessive force. The O.I.G. investigator determined that the complaint was substantiated because the staff person who had intervened had not been certified in P.A.R. techniques. The investigator ruled that there should have been other interventions done by the original staff person the girl was complaining to, before the second staff intervened.

There are additional examples of incidents where O.I.G. made a determination that the staff or facility was not following policy and procedures and that training was the root of the problem.

The original contract required Premier to ensure that its staff not take active duty until he/she had completed 120 hours of training. This requirement was based on the belief that this level and type of juvenile correctional program could not risk using untrained personnel to interact with "deep end" female offenders who also had mental health issues. The required training included forty (40) hours of orientation on issues such as gender specific treatment, rules of operation, and policies and procedures. An additional forty (40) hour block was to provide training in Protective Action Response. This involves the use of non physical de-escalation techniques and countermoves to a juveniles' violent behavior. P.A.R. also includes a matrix of various holds and take-downs that ensure the girls' safety as well as the staff's safety if performed properly and if the girl ceases resistance. Finally, the contract required a forty (40) hour block on first aid, CPR and other institutional health concerns.

A review of training records shows that F.I.G. was consistently out of compliance with this contract requirement. D.J.J. was either not aware or concerned with the facility's noncompliance. Rather, D.J.J.'s main interest was to ensure that this training was completed within six months of employment as it requires in other commitment programs.

D.J.J. requires all state employees who have direct contact with juveniles to attend and successfully complete a three (3) week academy. These training academies focus on professionalism, juvenile behavior, handling conflicts, verbal de-escalation and other pertinent topics. Private providers are not mandated to send its direct care staff to this academy; however, they may do so at a cost of approximately $225.00 per staff member. In addition, D.J.J. provides "Distance Learning" web based access to courses, at no cost to the provider. These courses are pertinent to any staff person working with juvenile offenders. At the time of this investigation F.I.G. had not taken advantage of the "Distance Learning" programs offered by D.J.J. nor the use of the Academy.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF STAFF TRAINING :

- Premier must comply with, and D.J.J. must enforce compliance with the original contract provision requiring 120 hours of training prior to staff having direct contact with the girls. The fact that this is not required in other high risk and maximum risk programs should not be the incentive to ignore this provision. The professionals who set these specific requirements believed this training was vital to prepare a staff person for the risks associated with this unique program. Premier can provide this training requirement of the contract in-house, or the requirement may be complied with by sending the direct care staff to the D.J.J. training academy to be certified in the same manner as state employees who work with juvenile offenders.

- F.I.G. must immediately arrange for use of the "Distance Learning" program offered through D.J.J. for all staff. Staff must be better trained on how to keep themselves safe by avoiding situations, as well as how to react when situations arise. Distance Learning is free to the provider. Topics such as ethics within the correctional environment, cultural diversity, security controls, stress management, emotionally disturbed offenders, suicide prevention and officer survival are vital to proper operation of this facility.

E. Protective Action Response:

Protective Action Response (hereinafter referred to as P.A.R.) is a program used statewide in juvenile facilities to deal with offenders who are out of control and defiant of all authority. This protocol requires the staff person to follow a matrix of intervention levels before touching the juvenile and eventually performing an actual takedown or the use of restraints. The levels include verbal de-escalation, physical restraint and mechanical restraints. P.A.R. mandates that verbal de-escalation be used prior to and during any touch. Within the physical restraint level there are five (5) response levels. These include touch, counter moves, control techniques, take-downs and pressure points.

When used properly this technique is the safest possible way to bring a juvenile offender under control in a relatively short amount of time, thus protecting the staff and the juvenile from harm. There will always be occasions of some physical injury to staff or the juvenile when the juvenile continues to violently resist all efforts of control.

Based on testimony and demonstrations, the Grand Jury finds this technique to be the best possible one for gaining control with the least possible injury.

An important step to accomplish de-escalation is "tap out". In this process the staff person who is originally involved in the altercation is "tapped out" by a neutral staff person. At that point the original staff removes him/herself from the situation. The neutral staff person then takes over the attempts to de-escalate or the moves to take-down. F.I.G. rarely used this de-escalation technique. One reason presented was the unavailability of staff when only two (2) are on shift with sixteen (16) girls. By the time more staff arrive the problem has escalated to a complete take-down.

Personnel who do not practice P.A.R. techniques often, lose their effectiveness and can misuse a technique. F.I.G. only provided one yearly refresher course.

Staff must be trained in P.A.R. prior to entering the dorms. A number of staff were not trained in P.A.R. for months after employment and still had daily contact with the girls. Staff who did receive training were allowed to work with the girls without passing their written certification test. The trained staff persons were not allowed to use P.A.R. techniques until certified. This certification test is given and scored by D.J.J. Results of these certification tests often took weeks to be made available to F.I.G. management.

Management including the Program Director, Assistant Directors and Chief of Security were not P.A.R. trained. This made them very ineffective and unavailable in requests for assistance with the girls.

Testimony further revealed that the girls were fully aware of P.A.R. techniques and which staff persons were certified in them. Girls pushed issues with the non-certified staff in an attempt to get staff to react improperly. The girls would then call the abuse line in an effort to get that staff person removed from the dorm.

The Grand Jury finds that Premier and F.I.G. management are at fault in these situations. They require staff to work in these dorms without being certified and thereby prohibit them from using this valuable tool. Then when staff is put in this position and choose to use a P.A.R. technique to handle the situation, they are terminated.

Testimony revealed that the girls acknowledge the need for P.A.R. techniques and that most injuries result from the girls' escalation of aggressive behavior once touched. However, the girls also indicate that staff are inconsistent in their use of verbal de-escalation in P.A.R. Some staff members attempt to de-escalate the situation with verbal prompts while other staff give one verbal command and then proceed to physical take-down. This inconsistency sends mixed messages to the girls and creates an appearance of favoritism by some staff. Similar transgressions committed by different girls would result in one staff person responding verbally to one transgression while another staff person would respond by a formal take-down.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF PROTECTIVE ACTION RESPONSE:

- Staff must be completely trained before taking active duty. P.A.R. certification tests must be completed prior to duty. If the staff member fails the test he/she must repeat the test within thirty (30) days. If certification is not achieved within sixty (60) days, staff shall be removed from direct contact with the girls.

- All administrative and management staff who may have contact with the girls must also receive the forty (40) hours of P.A.R. training and become certified within ninety (90) days of hire. Existing staff must do so by July 1, 2004.

- Staffing must be adequate to permit someone other than the original staff person who is in conflict with the girl to "tap out" and allow another to take over the attempts toward de-escalation.

- Refresher P.A.R. training must be mandated monthly for all P.A.R. trained employees.

- The P.A.R. trainer should review all incidents of take down from the security videos with the participating staff person within a week of the incident.

- D.J.J. must ensure that all P.A.R. written testing is available whenever necessary to achieve certification within ninety (90) days of hire. Also, D.J.J. must produce the scores for these tests within forty-eight (48) hours.

F. Reporting Requirements

O.I.G. has established mandatory guidelines for reporting incidents. The incident types are categorized as "A" or "B" list incidents. An "A" list incident must be reported to O.I.G. within two (2) hours of knowledge of the incident. A "B" list incident must be reported within twenty four (24) hours or the next business day. "A" list incidents include life threatening/endangering injuries to staff or juvenile, escapes, riots, felony arrests of staff, any allegation of abuse where physical injury results and outside medical assistance is required; and all allegations of romantic/sexual involvement between staff and juvenile. "B" list incidents include all other allegations of abuse, felony offenses committed by the juvenile, attempted escapes, recovery of drugs, alcohol or weapons from premises, battery on staff and any serious injury to staff or the juvenile.

Staff are required to complete a number of reports for incidents that occur in the facility. Incident reports are required anytime an "A" or "B" list incident occurs. Each staff person must prepare an account of the events that occurred. If the staff was involved in a take-down or any other use of a P.A.R. technique there must be a P.A.R. report. Additionally, anytime a girl is placed in disciplinary confinement, a confinement report must also be filed.

If the girl wishes to call the abuse hotline, staff must make the phone immediately available to her and report the allegation. A number of these incident reports are phoned into O.I.G., which will determine if there is a need for further investigation. If the incident reports are not completed, D.J.J. is not aware of any problems at the facility. This Grand Jury finds that these reporting requirements were not always met by F.I.G.

The following is an example of an incident that clearly demonstrates noncompliance with these requirements.

In July of 2003, a female juvenile offender suffered a broken arm. The testimony reveals that the incident was not reported to any agency until 7 days after the occurrence, in violation of all reporting requirements. In the statement given to a detective by the girl, she claimed that youth care worker "C" intentionally broke her left arm.

The incident began when the girl refused requests from youth care worker "D" to bathe. The girl started acting out, or "bucking", ignoring the many verbal prompts given

her to comply with requests. Assistance was given by youth care worker "C", an employee of seven months, who received her P.A.R. training approximately four (4) months after being hired, and who had not yet been P.A.R. certified.

As "C" holding the girl's right arm and "D" holding her left arm, attempted to direct her down the hall, other juvenile offenders were encouraging the girl to "buck" again. She abruptly stopped near the shower. A brief struggle ensued and the girl was taken down to the floor and her left arm was broken.

Contrary to the allegations from the girl, the surveillance video, made it apparent that "C" held the girl's right arm and was not responsible for the fracture of her left arm. This Grand Jury notes that the action is viewed and recorded from such a distance that it is impossible to determine if P.A.R. was performed properly.

The investigation shows "C" was not responsible for the fractured arm. This Grand Jury finds that there is lack of compliance not only with the policies and procedures in place at the F.I.G., but also with the clear provisions of the contract. Incident reports were not filed timely with O.I.G. and D.C.F. Once again Premier's practice placed staff in this untenable situation before being properly certified to assist.

This Grand Jury finds that the incident reporting process at F.I.G. contains no internal system to track incident reports and determine if these incidents were properly reported to O.I.G. There was no internal numbering system to indicate that incident reports were destroyed or missing. The only way for D.J.J. to monitor these reports was by monitoring the abuse calls made to the D.C.F., then D.J.J. requesting copies of the incident reports that should have been completed.

In the course of its investigation, the Grand Jury found abuse call reports that had no corresponding O.I.G. incident report. Explanations for this occurrence are limited to either a lost or destroyed document at F.I.G. or the facility staff never prepared the report. All explanations are insufficient and contrary to contractual obligations.

This Grand Jury subpoenaed records from F.I.G., D.J.J., D.C.F. and O.I.G. It found no system in place that ensured that each agency had copies of all relevant reports concerning F.I.G. D.C.F. had abuse reports that had no required corresponding O.I.G. report. O.I.G. had incident reports that listed D.C.F. personnel, but D.C.F. did not have

the abuse report for these cases. Finally, F.I.G. had reports that were not found in D.C.F. or O.I.G. and lacked reports found in the other agencies. In summary, no agency could submit a complete set of requested reports.

This Grand Jury finds that this reporting requirement is a contractual obligation. There exists no process to match necessary reports or explain missing reports. Further, this Grand Jury recognizes that copies received under subpoena did not reflect all copies of the incidents; however, accurate retention of such records is mandated.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF REPORTING REQUIREMENTS:

- All mandatory reports must have control numbers preassigned to enable management to audit all complaints and determine if any are missing, lost or destroyed.

- The program director at F.I.G. is to be held ultimately responsible to ensure that all incidents are properly reported both internally and to the necessary outside agencies. The program director must be the chief custodian for the maintenance of the records.

G. Document Destruction or Alteration

F.I.G. is reviewed by a team of peers under the Quality Assurance Program. The facility is notified by D.J.J. thirty (30) days prior to the review. A practice of altering or destroying documents prior to the review was brought to the attention of the Grand Jury, though much of the testimony on this issue was in conflict. Staff would recall incidents of being asked to rewrite, sign or back date documents that were necessary for this quality assurance audit. Management insisted that no one under their authority ever asked staff to do this. An allegation of document destruction was made; however, the grand jury found no other evidence to support this allegation. Though this Grand Jury could make no finding of criminal responsibility, this testimony made it apparent that there were major trust issues between the staff and the management at F.I.G.

H. False Reports of Abuse

Professionals testified that issues such as past physical and sexual abuse by males in the girls' lives surface in the program when a male staff member redirects or corrects the female offender. False allegations of abuse become prevalent as a way for the girls to prove they have control over their situations.

False allegations are also used to exact revenge on a staff person who has just disciplined the girl. Immediate removal of the staff from that dorm is mandated once a girl issues a complaint against the staff for abuse. This gives the girls a sense of power over the staff. There are no internal consequences for false allegations made by the girls.

Examples of this type of manipulation include over twenty false allegations of abuse called into the Abuse Hotline by one girl. Another girl called in at least twelve false reports. The Grand Jury finds that every call was investigated by a D.C.F. Protective Investigator and a law enforcement officer.

False allegations have a significant impact on staff. Such allegations result in unpaid suspension, resignation, staff shortages, stress, and possible placement of the alleged abuser's name on the state abuse registry, thus damaging his/her reputation. Further, false allegations affect other staff who are then forced to work additional shifts. Consequently, morale is lowered when staff worry that the next false allegation will be lodged against them.

The Grand Jury finds that false allegations can also make a girl more vulnerable to actual abuse by an inappropriate staff person who believes he/she can take advantage of the girl's lack of credibility after numerous prior false allegations.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF FALSE REPORTS :

- There must be severe consequences for false reports by the girls of abuse or sexual contact. The consequence for false reporting must be the addition of time to the girls projected release date, and the loss of points or level within

the behavior management program. Additionally, there should be a review to consider the filing of criminal charges.

I. Battery on Staff

A common belief among the girls was that if they hurt staff, they would eventually be sent to another program or the adult court. In an effort to control this type of behavior, the majority of cases involving battery on staff were handled in juvenile court where the last possible sentence was to return to the High or Maximum Risk program at F.I.G.

This Grand Jury reviewed forty-two (42) cases of Battery on Staff from the girls in this facility. One girl in particular was responsible for as many as nine (9) of these crimes. Some examples of these cases include a girl punching the Program Director in the face shattering her nose; another girl grabbing a staff person and throwing her against the wall; another girl tackling a staff person to the ground and banging her head on the concrete floor; a girl throwing feces onto a staff person; a girl striking a protective investigator during an interview; and numerous incidents of girls biting, punching, kicking and hitting staff.

Eventually, as the girls continued to batter staff, they were considered for prosecution as adults. If their prior offenses resulted in a Criminal Punishment Code score for incarceration in the Department of Corrections for at least three years, they were sent to adult felony court.

Once in adult court, the girls have found that some of the circuit judges and felony attorneys downplay the seriousness of this behavior. This attitude results in a sentence that is below the Criminal Punishment Code minimum sentence for the female juvenile offender. This type of sentence removes the girls from F.I.G., where they may serve up to three years, and places them in an adult facility for less than that three year time period. The girls know that there is no requirement to attend group therapy or individual therapy sessions in the adult facility; therefore, their stay is considered easier. Consequently, there is often no significant penalty for injuring a staff person while committed in this facility.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF BATTERY ON STAFF:

- If prosecuted in juvenile court the girls must be recommitted back to F.I.G. Addition of time to projected release dates and loss of level within the behavior management system must also be included.

- If prosecuted in adult court, Criminal judges should seriously consider the affect of their sentence on the girls at F.I.G. They should ensure that any sentence meets or exceeds the minimum the girl was to serve at F.I.G.

IV. SERVICES FOR GIRLS

Another area of investigation was the services available which directly affect the behavior and rehabilitation of the girls placed in F.I.G. These include daily activities, education, medical services, behavior management program, therapeutic services, grievance procedures and transitional programming.

1. DAILY ACTIVITIES

The daily routine at F.I.G. started with wake-up calls at 5:00am and a half hour of exercise, followed by showers and breakfast. School followed the normal six hour requirement. Then, the girls alternated their group sessions and individual therapy sessions. This was followed by reading time, outdoor recreation, and dinner. The day concluded with more reading, writing time, snack and then phone calls. The day finished with quiet time and lights out at 9:00 p.m.

The activities highly valued by the girls, such as school, group sessions, crafts, outdoor recreation and visitation were often cancelled due to unavailability of staff, or disciplinary problems. This caused the girls to be locked down in their rooms. The cancellation of activities lead to further disruptions by the girls, especially on those days when no physical activity was provided to burn off energy and stress. The Grand Jury finds that a key to daily success is no disruption of the scheduled routine for these girls.

The recreational activities provided at F.I.G. appear to be limited to basketball and volleyball. Past attempts to expand this list to include programs such as yoga, aerobics, and dance have failed due to staff shortage.

Outside recreation and/or physical fitness activities are not considered a high priority by F.I.G., as evidenced by testimony from many witnesses. Lack of trained staff, a limited amount of equipment and insufficient recreation time contributed to some of the incidents reported at F.I.G.

Evidence showed two local high risk and maximum risk boys facilities stress the importance of physical fitness. All boys are evaluated individually on their physical fitness level, including body fat percentage. They are provided a weight lifting regimen to meet their needs. A staff person monitors and evaluates each boy's physical fitness level.

In addition, these boys programs provide a variety of outdoor sports such as basketball, volleyball and softball; and have tournaments in each sport on a regular basis to teach good sportsmanship.

A wide variety of indoor recreation activities are also provided at the boys facilities that are not found to be available for the girls at F.I.G. Activities that center on popular sports events and other events, including "family days", are planned for the boys year round. Bingo, puzzles, art sessions and roaming libraries are also provided. In addition, educational activities are created around TV game shows, such as "Family Feud" and "Jeopardy". DVD's and video games are also provided to boys who have earned the privilege.

Testimony about activities at F.I.G. focused on the promise of new programs but never the follow-through by management. Testimony revealed there is a problem with weight gain at this facility. An aerobics class was promised but not instituted.

Another example of this was the community outreach programs that volunteered their time to work with the girls. These activities were often cancelled due to staff shortages or disruptive behavior. No other attempts to bring these programs back into F.I.G. were made.

In reviewing the daily activity schedules the Grand Jury finds a number of hours of downtime that could be used more effectively for the girls.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF DAILY ACTIVITIES:

- The girls must be active enough during the day to tire them out by evening. More outdoor time and exercise of various types must be used.

- A trained staff person must be available for daily recreation for the girls. This would help alleviate the problem of insufficient staff and possible lock-down situations.

- Various outdoor sports and activities, such as soccer and whiffleball, must be offered to the girls, in addition to having basketball and volleyball activities.

- Physical fitness must be a major emphasis for the girls. Individualized fitness plans must be developed for each girl and monitored by trained staff. Appropriate weight lifting and cardiovascular equipment must be provided. F.I.G. should communicate with the boys' facilities to determine how to accomplish recreation and still maintain safety and security.

- Management must create more indoor activities, including games and arts and crafts projects. Activities such as, but not limited to, dance, yoga, and aerobics must also be provided on a weekly basis.

- Additional and enhanced community volunteer programs must be brought into the facility.

2. EDUCATIONAL SERVICES

The School District of Palm Beach County staffs the educational unit of the facility. There are eight (8) teachers assigned to this facility and all are committed to their work in alternative education. The teachers are dedicated to working with these girls to achieve their highest level of education and, in fact, requested this assignment. Classes are held year-round. Teachers are required to create multiple curriculum for their classes based on the various levels of education within which these girls function. The teacher is responsible for the operation of the classroom; however, at least two (2) F.I.G. staff persons are required to be in attendance at all times. There was evidence that the required presence of two staff members in the classroom at all times was ignored whenever there were staffing problems in the facility.

There appear to be some issues concerning the staff persons interference with the classroom environment. Some staff had a tendency to talk to the girls while in class and disrupted the learning environment.

Staff are responsible for the immediate response to inappropriate classroom behavior that may place the teacher or girls in danger. They are also responsible for the removal of the offender from the classroom. Testimony and a review of incident reports show the majority of girls are motivated in their class work. Minimal incident reports during these time periods indicate the girls are least disruptive during class.

The school has also developed a GED program for those offenders who are older and no longer on a direct path to their high school diploma.

The school provides two special education teachers to meet the needs of any girl who has been determined to qualify under the Federal Americans with Disabilities Act and the Individuals with Disabilities Education Act. If a girl enters the facility with no record of any special testing or diagnoses having been completed by her prior school district, she will be placed in regular classes. If a learning difficulty is detected by the teacher the girls will be referred for evaluation. This Grand Jury is concerned about the length of time it takes to determine if an offender qualifies for special education programming. Testimony and documentation revealed a process that takes 3-4 months to complete. In the interim, these girls are in the wrong school setting and often become disruptive when their needs are not met.

The classrooms have computers. Computer use is limited and based on the level of behavior of the girl.

The Grand Jury finds that the facility cancelled classes forty one (41) times in the course of a six and one half (6 ½) month period in 2003 due to facility staff shortages. The teachers were prepared for class, but the facility could not produce enough staff persons to allow classes to proceed.

School officials note a marked improvement over the last six (6) months resulting in only a few cancellations. This Grand Jury notes that this improvement coincides with the time period when D.J.J. and Premier introduced more staff into the facility as an

emergency response to crises and a D.J.J. ordered reduction of the number of girls at F.I.G.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF EDUCATION OF THE GIRLS:

- Two staff members must always be present in the classroom with the teacher and girls. F.I.G. must have sufficient staff so that school classes are not cancelled due to F.I.G. staffing shortages.

- Staff members must be trained in how to cooperate with the teachers and girls during classroom time. Staff members must contribute to the learning environment, not detract from it.

- Teachers must have the authority to control the classroom environment or direct staff to remove disruptive students.

- Teachers must help reinforce facility rules during classroom time.

- F.I.G. management must include the teachers in planning and evaluating the behavior management program.

- Positive classroom behavior and academic achievement should be rewarded through more computer access and other positive rewards.

- Students should be evaluated for special education programming at the facility within thirty (30) days of a recommendation from the teacher.

- The recent addition of recreation/physical education during the school hours must continue and be extended to after-school.

3. MEDICAL SERVICES

The facility has a nursing staff on duty approximately 10-12 hours on weekdays with doctor visits scheduled once a week. Although the nurses may be on-call, they are not physically present in the evenings and weekends.

Testimony revealed that a number of the girls are not taking their medication; and in fact, hide it and try to give it to others.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF MEDICAL ISSUES:

- Nursing staff must ensure that each girl has consumed her medication.
- Nursing staff should be on-site daily.

4. BEHAVIOR MANAGEMENT

This Grand Jury notes that this facility of high level incarceration for delinquent girls with mental health issues is the first of its kind in Florida. However, the program has received failing scores for its behavior management programming in 2001, 2002, and 2003. It is recognized that each time the facility failed in this area, it submitted a new plan , but all attempts have failed. This inability to address the behavior of these girls is a direct contributor to the continuing violence in this facility.

Behavior management programming is a vital component to any juvenile correctional program. However, in this particular facility with girls with mental health issues, it is paramount that a successful behavior management program be in place. The offenders must have some incentive to abide by the rules and work within the program. Offenders who have no incentive, simply disrupt the facility with no true fear of consequences. Basically, the attitude is, "I'm locked up for 1-3 years anyway. What more can you do to me?"

The girls must understand that the program has both rewards for good behavior and consequences for bad behavior. Thus far, a number of the girls who have no interest in successfully working the program have been able to disrupt the program for everyone else. This program is the highest level program a female juvenile offender can reach. This creates a problem of determining consequences for bad behavior. However, consequences can be determined with skilled motivated experts addressing the issue, including teachers and therapists.

Often, the goal of these more disruptive girls is to be removed from the program, even if it requires the commission of a criminal act that may result in prosecution as an adult. Adult prison holds no fear for these girls. Many of them have been incarcerated in juvenile programs for several years. Adult prison does not require therapy sessions, group

sessions and schooling, so the girls believe that prison would be an easier place to "do their time".

The mixing of delinquent girls with the severely mentally disabled delinquent girls in various dorms has also lead to the violence in F.I.G. The violence in the dorms often resulted from either the disturbed girls acting out, or the delinquent girls showing intolerance of those girls with mental health issues. One or two girls could disrupt the entire dorm. With staffing patterns designed for two (2) staff per dorm, outrageous behavior by one girl often required the lock down of at least eight other girls simply because there was not enough staff to handle both groups. This process penalizes compliant girls unjustly.

This Grand Jury finds that past behavior management plans had not included the professional input of teachers or therapists until the plan was already being implemented. F.I.G. management was negligent in not accessing professional opinions from all disciplines within the program.

Testimony established that past management plans were not accepted by the girls because they believed management would hold out promises of reward or activity for good behavior and then renege on the promise.

Currently, the new management has developed a behavior management program that places girls who are on the same level of behavior together in the same dorm. This results in girls, who score positive points and who are working within the program, being housed together in "Gold dorms". Those who are stumbling but trying to achieve success are housed together in the "Silver dorms." Those who are disruptive and never seek to earn enough points to move up in the program are housed together in the "Bronze dorm". A fourth dorm will be opened as an "orientation dorm" to separate the new arrivals for a period of time. Girls in Silver and Bronze dorms are given numerous opportunities to improve their scores and behavior and move to higher level dorms. The higher the dorm level, the greater the privileges extended to the girls in the dorm.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF BEHAVIOR MANAGEMENT:

- F.I.G. must maintain the separation of girls based on behavior levels.
- Privileges must be increased for those who achieve good behavior and social skills. Examples of such privileges include access to facility approved video games, movies, and DVD's, increased telephone time, or additional physical activities..
- F.I.G. management must include input from teachers and therapists in behavior management decisions.
- Staff and management must keep promises made to the girls and maintain consistency in making those promises.
- F.I.G. programming must encourage family involvement.

5. THERAPEUTIC SERVICES

F.I.G. receives a number of female juvenile offenders whose mental health issues have contributed to behaviors that make them unmanageable in the other juvenile justice residential commitment programs. Upon entering F.I.G., the girls are given a basic mental health assessment, but there is no psycho-social assessment done to assist in creating a mental health treatment plan. If the therapist is not certified to perform this assessment, the girls' treatment plans are lacking in this area.

Testimony indicates that approximately 71% of the girls at F.I.G. have major mental health issues in addition to their delinquent behavior. 65% of the girls have been subjected to some type of sexual abuse; 60% are learning disabled; and 62% have some sort of substance abuse problem when they enter the program.

F.I.G. has therapists who work with the girls in individual therapy as well as group therapy sessions. Individual therapy sessions are scheduled once every two weeks. Group therapy sessions are held daily on various topics. Girls who are not specifically ordered by the court to attend therapy sessions can opt out of attending. The only consequence for non-attendance then, is the loss of points toward their next level. This will ultimately result in their serving the maximum time in the program with no hope for release once

their minimum mandatory time has been served. These girls are continually disruptive in the program with no apparent intention of changing their behavior during their stay.

The Grand Jury finds that F.I.G. was originally started as a juvenile corrections facility for girls with some mental health issues. However, the mental health issues for many of these girls are so pronounced that the program must respond more as a mental health facility for girls who are also delinquent. Some examples of the mental health issues the program is dealing with include: suicidal ideation, self mutilation, psychosis and schizophrenia. These are in addition to more common mental health issues such as depression, conduct disorders, oppositional defiance, and post traumatic stress disorder.

Unfortunately, this program is not staffed nor designed to be a secure mental health facility. F.I.G. is not legislatively funded for severe mental health services. It is funded as a juvenile corrections program with some wrap-around mental health services included. Corrections programming does not adequately address these individual concerns.

F.I.G. management did not recognize the significant role therapists play in the daily operation of this facility. Testimony and evidence show repeated decisions made by management which cancelled or disrupted therapy, including shifting girls from one therapist to another. This was compounded by the fact that therapists did not make monthly reports on the girls' mental health. In addition, there were no therapists scheduled in the evenings when the girls were most disruptive. Further, therapists rarely met as a team to discuss issues arising from the girls' behavior and how these issues affected the smooth operation of the facility.

Many of these offenders are in need of the treatment and therapeutic sessions that qualify under Medicaid, but they can no longer access these services because they are incarcerated by the State in a high or maximum risk facility. Premier is responsible for providing all the juveniles's medical and mental health needs up to $7500 through their contracted dollars. Services beyond this contracted amount must be approved and paid directly by D.J.J.

The Grand Jury finds that it takes a very special person to work in this facility. There is no psychological assessment used prior to hiring youth care workers that would

identify those most capable of working with this population and those who are likely to take advantage of the girls' vulnerabilities.

Again, this Grand Jury finds that the lack of training is key to many problems the staff must address on a daily basis. F.I.G. staff are not adequately trained to deal with girls with these mental health issues. The work environment is stressful and often too overwhelming for the average staff person. The girls mental health issues combined with their institutionalization cause an atmosphere of manipulation and distrust, resulting in abuse by staff and by the girls. Staff had limited access to the therapists to learn techniques for dealing with the girls.

Finally, this Grand Jury is greatly concerned over the erasure of valuable mental health information from a therapist's computer in September 2003. Regardless of whether this erasure was the result of technical error or intentional destruction, the result was the loss of pertinent treatment information on certain girls. This type of data must be safeguarded by all employees.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF THERAPEUTIC ISSUES:

- Therapists must be physically present during times of most disruptive behaviors. F.I.G. must adjust therapist schedules and add additional therapists to ensure their availability until bedtime and on the weekends to assist the youth care workers with the day-to-day behavior issues of these girls.

- F.I.G. must hire a therapist with expertise in sexual victimization.

- All therapists must complete psycho-social evaluations upon the girls' entry into the facility.

- Therapists must complete monthly progress reports on each girl.

- Therapists must provide training to staff on dealing with girls with mental health issues. F.I.G. must investigate opportunities to cross train the youth care workers as certified behavior health technicians.

- The clinical team must meet monthly to discuss therapeutic issues regarding the girls and how these issues affect the daily operation of the facility.

- D.J.J. must ensure that the facility accepts no more girls than the number funded for mental health treatment by the contract. In the alternative, additional money should be provided by Premier, D.J.J. or the legislature to more adequately meet the mental health needs of these offenders and ensure the safety and well being of everyone in F.I.G.

- The computers must not be used touched by "information resource" personnel without verifying or conducting a back-up of all data.

6. GRIEVANCE PROCEDURE

D.J.J. standards for commitment programs require the facility to have a grievance procedure in place for the girls. Although F.I.G. had a system in place, it was not easily accessible to the girls and was not conducive to "airing their grievances". The process resulted in the complaint often being ignored by the staff. This resulted in the girls accessing the D.C.F. hotline for many of their complaints because all abuse calls mandate a protective investigator to report to the facility and speak to the girls.

A complaint of the girls was that the staff was constantly attending to those girls who were disruptive. The girls believe that the only time they received any personal attention from staff was when they acted out. Girls requested more emphasis on good behavior. Girls need quality time with staff as a reward for good behavior and not just material rewards or points. The girls believed that management lied to them and made promises that were not fulfilled. This fostered a hopeless feeling in the girls. Disruptive behavior was then used as a means to retaliate.

The grievance process has changed with the new management, but there is no indication yet of its success. The new procedure is set up to enable each girl to complete a grievance form. That form is picked up from a grievance box once a day by management. The Program Director and the Director of Operations make a point of reviewing each grievance and immediately following through with a response directly to the girl. This process has reduced the number of abuse calls made by the girls because management is more responsive to the girls and their needs.

7. TRANSITIONAL PROGRAMMING

The girls in this facility spend anywhere from one (1) year to three (3) years institutionalized. This Grand Jury finds no adequate transitional programming at F.I.G. to assist the girls with their return to the community.

Quality Assurance evaluations found F.I.G. to be deficient in this area. In 2001 F.I.G. received a score of thirty (30) which placed them in the "failed" category. In 2002 and 2003 they scored sixty three (63) which placed them four (4) points above "failed" to the "minimum performance" category. The Grand Jury found a strong regimen of instruction on life skills such as balancing a checking account, making a budget, preparing for job interviews, creating resumes, maintaining personal relations and independent living was missing at F.I.G.

The contract requires that instruction and education shall be provided in the areas of life skills and employability skills. Vocational education and experience specifically designed for female youth shall also be provided. Testimony revealed little progress in these areas. F.I.G. is fortunate to have state of the art computer graphics equipment in the facility. However, this has not been available to the girls on a regular basis due to the lack of trained staff.

THE GRAND JURY RECOMMENDS THE FOLLOWING IN THE AREA OF TRANSITIONAL/VOCATIONAL PROGRAMMING:

- Computer training and other technical/trade training must be provided in the girls schedule, outside their normal educational blocks of time.

- F.I.G. must provide a regimen of instruction within the last eight (8) weeks of incarceration that focuses on the life skills, job skills and social skills each girl will need to successfully return to her community.

V. THE VOICE OF THE GIRLS:

This Grand Jury finds that there are a group of approximately thirty (30) girls in this facility that are causing the most disturbance. In a review of incident reports this Grand Jury found a clear majority of the girls did not report any abuse and were not involved in incidents involving staff. Many of those girls who did report abuse did so on multiple occasions.

Testimony revealed that a number of the girls in F.I.G. were working toward improving their lives. They were very positive about the help they received after being placed at the facility. They took advantage of the therapy sessions offered and excelled in their studies. They may not have liked the way the program was run, but they were able to accept that their behavior caused them to be locked up and their behavior would eventually be the key to their freedom. They had very positive attitudes about their futures. They stated most of the staff were helpful, but they avoided those who were only there for a paycheck. This type of staff person was easily identified by the girls and often were the ones who played favorites and were inconsistent in their discipline.

The successful girls felt that the greatest obstacle to successful completion of the program was the disruptive behaviors of some of the girls. The Grand Jury finds that the time and energy it took the staff to control these situations left little time for the girls who were trying to work the program successfully. "The bad girls got all the attention while the good girls were ignored."

VI. INVOLVEMENT OF OUTSIDE AGENCIES

1. PALM BEACH COUNTY SHERIFF'S OFFICE

The Palm Beach County Sheriff's Office accompanies each protective investigator from the D.C.F. who must respond to the program when a girl calls the abuse hotline. Deputies or Detectives also respond to calls of violence and any criminal activity within the facility. These calls numbered approximately 298 for the last two (2) years. Upon

comparison the calls from F.I.G. (housing approximately 100 girls) equaled the calls from a boys facility housing 300 boys.

The cost to Palm Beach County tax payers included hundreds of hours and thousands of dollars per year to respond to these calls to F.I.G. Every county or municipality in Florida that houses a D.J.J. residential commitment program suffers similar costs though apparently not to this magnitude.

This Grand Jury found the response of the P.B.S.O. officers to be timely and appropriate. The Special Investigations Unit investigates allegations of abuse on a girl by a staff person. Detectives from this unit have also spent hours counseling the girls concerning the commission of crimes at F.I.G. and the consequences of false reporting.

The Grand Jury finds that P.B.S.O. is a valuable community partner to the Florida Institute for Girls.

2. DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families is mandated by law to send a Protective Investigator to F.I.G. when a girl who is incarcerated in that facility calls the hotline with an allegation of abuse. The protective investigator talks to the girl, witnesses, staff and management and makes a determination as to whether the allegation is "founded" or "unfounded". The vast majority of calls made from the Florida Institute for Girls were categorized as unfounded.

Any calls determined to be "founded" were discussed with management, and the alleged perpetrator was immediately removed from contact with all girls. These cases could result in criminal charges being referred to the State Attorneys Office, suspension or termination of employment. The Grand Jury finds that D.C.F. is an important line of defense for the girls' safety. Their joint investigations with P.B.S.O. ensure an independent eye looking toward the protection of the girls at F.I.G.

3. STATE ATTORNEY'S OFFICE

The juvenile division of the State Attorney's Office received and reviewed all cases where girls under age eighteen (18) were arrested for either battery on staff, battery

on another girl or false report of abuse. If the review revealed cases with evidence that was sufficient to produce a substantial likelihood of conviction charges were filed. There were a total of fifty-two (52) cases received by this office for filing between April 2000 and September 2003. Forty-two (42) of the fifty (50) cases filed in juvenile court resulted in a conviction. The dispositions of these cases resulted in either a recommitment back to F.I.G., or a transfer of sentencing back to the home county of the girl. This policy of recommitment back to F.I.G. was based on the fact that the girls were already in the highest and longest term residential commitment program in Florida; and therefore, no other sentence was available.

On occasion, the State Attorney's Office was asked to consider sending some of the girls to adult court. In many situations, the girls did not score high enough in the Criminal Punishment Code to ensure they would serve at least the same amount of time in adult prison as they were already ordered to serve in F.I.G. Another consideration involved the question of whether a girl's violent behavior was in anyway affected by the medications she was taking to deal with her mental health issues. In such cases, the State Attorneys Office believed that continued treatment at F.I.G. was the best resolution of the case.

Approximately four girls were sent to adult court in 2002/2003. Two were sentenced to the Department of Corrections for at least three (3) years. The other two girls received minimal sentences to county jail. The Grand Jury was disappointed to find these county jail sentences were below the minimum recommendations of the Criminal Punishment Code and even less than the girls' remaining sentence at F.I.G.

The Crimes Against Children Unit also handled investigations into, and the prosecution of, criminal allegations against several F.I.G. employees. The prosecutors involved in these cases were thorough in their evaluations of the evidence presented: they not only interviewed the child victims and witnesses, but also went so far as to visit the facility to determine if witnesses could have seen the actions described in their statements. In those cases where there was sufficient credible evidence, criminal charges were filed.

Once these cases were filed, the prosecutors began preparing for trial. As the discovery process (i.e. depositions) proceeded, the prosecutors had to make additional

evaluations of the cases' likelihood of conviction at trial. This additional analysis was necessary due to the reluctance of some victims to testify and conflicting statements from witnesses during their depositions. As part of this evaluation, the prosecutors had to balance the likelihood of success at trial with several other factors: the trauma to the victim should she have to testify, future safeguards to protect the victim from the offender and protection of other minors.

After considering all the above, settlements or plea offers were extended as outlined within this report. Based upon the evidence before the Grand Jury, the results in each case were appropriate and succeeded in punishing the offender, while also providing safeguards to protect the victim and the community.

It is the further finding of the Grand Jury that the State Attorney's Office was thorough in its investigation of cases arising from the facility and the prosecution of those cases that were filed.

VII. IMPROVEMENT AT F.I.G.

Media coverage and the convening of this Grand Jury has brought change to the Florida Institute for Girls. A new program director was hired in August. She believes in being accessible to her staff and the girls. She has consulted with her teachers and therapists on a limited basis. She is including the vice-principal and clinical director in her weekly management staff meetings. Additionally, the program director has created a new staffing schedule that allows for an eight-hour block of training.

Premier brought in staff from other programs and restructured the management team at F.I.G. Premier also brought in a consultant to review the behavior management plan and its expectations. A program of behavior management that focuses on levels of positive behavior has been initiated. The girls' grievance procedures have been revamped. Hiring and training of staff are underway.

D.J.J. reduced the number of girls in the facility and added its own employees to increase staff. A new contract monitor was assigned to monitor F.I.G. The new contract monitor has increased her visits to the program. D.J.J. purchased software to enable the

regional director and contact monitor to use their computers to view security tapes from F.I.G. in real time.

Local D.J.J. has initiated a new requirement that all corrective action plans submitted by F.I.G. must include performance measures. D.J.J. has issued a mandate to all contracted providers requiring the sharing of information on any staff person who is terminated from employment for inappropriate behavior. Local D.J.J. is linking with D.C.F. to monitor all abuse calls originating from F.I.G. and the other contracted facilities in this region.

These are a few of the improvements that have taken place at F.I.G. This Grand Jury recognizes the effort that has been expended to bring order to this facility. However, the Grand Jury recommendations must be executed to help ensure the safety and well-being of the girls and staff.

VIII. CONCLUSION

This Grand Jury recognizes the need for an institution such as F.I.G. in incarcerate juvenile female offenders. D.J.J. and Premier must ensure the girls at F.I.G. are safe and are receiving appropriate rehabilitative services while serving their sentences. We recognize that most employees at F.I.G. are dedicated, hard-working professionals pursuing a mission to improve the girls' lives while attempting to ensure their safety. We acknowledge the efforts of most of the girls incarcerated at F.I.G. to rehabilitate themselves. A minority of the girls disrupts the daily activities and monopolizes the attention of the staff and services.

It is imperative that Premier maintains adequate staffing. **Inadequate staffing** breeds and environment that has a potential for sexual abuse of the girls as proven in the Larry Curry and Jason Crawford cases. Unjustified lock-downs due to a staff shortage result in an aggressive rebellious behavior in the girls. Inadequate staffing is a serious contract violation, endangering both girls and staff. D.J.J. must not tolerate the practice of locking down the girls at F.I.G. for extended periods due to inadequate staffing. D.J.J. must terminate the contract with Premier if inadequate staffing persists.

Premier and D.J.J. must ensure the contract mandate for 120 hours of **staff training** prior to direct contact with the girls be followed at F.I.G. Training records indicate that F.I.G. was consistently out of compliance. This deficiency led to safety issues resulting in serious injuries to the girls and batteries on staff. D.J.J. must give notice to Premier that as of July 1, 2004 noncompliance will result in contract default and termination.

Premier must implement a successful **behavior management** program at F.I.G. F.I.G. failed the yearly Quality Assurance reviews on behavior management since its inception in 2000. Behavior management is a vital component to any juvenile correction program. F.I.G.'s inability to address the behavior of these girls is a direct contributor to the continuing violence in this facility. Current trends at F.I.G. of a new behavior management program appear to be positive. D.J.J. must monitor the behavior management program for progress towards an acceptable rating. D.J.J. should terminate the contract with Premier if F.I.G. does not make adequate progress in this area.

This Grand Jury summarizes its extensive investigation in the following statement. While these female juvenile offenders are incarcerated at F.I.G., it is the responsibility of D.J.J. and Premier to ensure the girls are safe and receive appropriate services to assist them in returning to their communities as law-abiding citizens. **This is what our tax dollars are paying for and anything less is unacceptable to the citizens of this State.**

This Grand Jury directs Premier Behavioral Solutions, Inc., or the current contracted provider for F.I.G., and the Department of Juvenile Justice return to the empaneled Grand Jury in six (6) and eighteen (18) months to report on the status and implementation of all recommendations.

* It is the Grand Jury's request that this report be furnished to the following:

Honorable Jeb Bush, Governor of Florida
James E. King, President of the Senate
Johnnie Byrd, Speaker of the House
Palm Beach County Legislative Delegation Chairman Joe Negron
Department of Juvenile Justice Secretary W.G. "Bill" Bankhead
Department of Juvenile Justice Assistant Secretary of Residential and Correctional Facilities Charles Chervanik
Department of Juvenile Justice General Counsel Jennifer Parker
Department of Juvenile Justice Regional Director Darryl Olson
Department of Children and Families Secretary James Regier
Department of Children and Families District Administrator Ted Simpkins
Premier Behavioral Solutions, Inc. Regional Director Jorge Ricco
Florida Institute for Girls Director Cindy Spence
Honorable Judge Edward H. Fine
Honorable Judge Karen Martin
Honorable Judge Ronald V. Alvarez
Honorable Judge Moses Baker
Honorable Judge Roger Colton
Honorable Judge Harold Cohen
Palm Beach County Sheriff Ed Bieluch
Palm Beach Sheriff's Office Captain James Stormes
Palm Beach County School Board Superintendent Art Johnson
Palm Beach County School Board Director of Alternative Education Mary Vreeland
Palm Beach County Juvenile Justice Board
Palm Beach County Community Alliance

Respectfully submits this unanimous report this the 29th day of January, 2004.

_____"_original signed"_____
FOREPERSON OF THE GRAND JURY

As authorized and required by law, we have advised the Grand Jury returning this presentment.

_____"original signed"_____
JEANNE D. HOWARD
ASSISTANT STATE ATTORNEY
FIFTEENTH JUDICIAL CIRCUIT

_____"original signed"_____
LANNA BELOHLAVEK
ASSISTANT STATE ATTORNEY
FIFTEENTH JUDICIAL CIRCUIT

* This page was corrected for scrivener's error on 2/17/04.