FINAL REPORT OF THE MIAMI-DADE COUNTY GRAND JURY

Investigation into the Death of Omar Paisley and the Department of Juvenile Justice Miami-Dade Regional Juvenile Detention Center

SUMMARY OF RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. We recommend that the Department of Juvenile Justice re-assess the current exemption

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

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

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

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

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