The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CRIMINAL JUSTICE
Senator Evers, Chair
Senator Gibson, Vice Chair

MEETING DATE: Tuesday, January 20, 2015
TIME: 3:30 —5:00 p.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Office Building

MEMBERS: Senator Evers, Chair; Senator Gibson, Vice Chair; Senators Bradley, Brandes, and Clemens

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Presentation by Secretary Julie Jones, Florida Department of Corrections, on: A general status report on the department, including a report on the Office of Inspector General's FY 2013-14 Annual Report and the increase in the use of force incidents; and The recent departmental efforts to identify deficiencies and implement changes related to staffing, officer misconduct, facility maintenance and repair, inmate deaths, inmate health care, and inmate mental health treatment.	Presented
2		Presentation by the Office of Program Policy Analysis and Government Accountability on independent oversight mechanisms for correctional institutions and systems in other states.	Presented
3		Presentation by the Florida Correctional Medical Authority on its history since the Costello v. Wainwright class action lawsuit, its activities since the Osterback v. Crosby agreement, its 2013-14 Annual Report, and its Annual Report on Elderly Offenders.	Presented
4		Presentation by Florida TaxWatch on its report: "Florida's Aging Prisoner Problem"	Not Considered
		Other Related Meeting Documents	

Florida Department of Corrections

Update

Senate Committee on Criminal Justice
January 20, 2015

Julie Jones, Secretary

First 100 Days

- Continuing Ongoing Reforms
- Budget Emphasis:
  - Salary
  - Fixed Capital Outlay
  - Expense
- Fiscal Audit
- Public Records Emphasis
- Staffing and Positions Assessment / Update

First 100 Days

- Communications Plan: Internal and External
- Community Programs Initiative
- Use of Force Analysis
- Mental Healthcare Expansion
- Stakeholder Outreach

Inspector General Update

- Past:
  - 82 Investigations
- Present:
  - Annual Inspector General Report
- Future:
  - Memorandum of Understanding
  - Analytics
  - Policy and Procedure Review
  - Third Party Review Authorities

Use of Force

Department staff are authorized in accordance with 944.35, Florida Statutes and Rule 33-602.210, Florida Administrative Code to utilize physical force in response to inmate acts that require its use as a last resort to maintain order and a safe and secure environment for staff and inmates alike.

- Use of Force investigated by the Inspector General
- IG Office comprised of certified law enforcement
- Continuum of Use of Force
- Use of Force is a response to precipitating actions by inmates

Use of Force

During FY 2013-14 there was an increase of 1000 Use of Force incidents (16% increase) over the prior year. This increase occurred in three Use of Force incident types:

- Staff Use of Force in self defense
- Staff Use of Force to quell disturbances
- Staff Use of Force to manage inmate physical resistance to a lawful command

During this same time period there was an increase in the frequency of inmate misconduct. There were an additional 2,812 (18% increase) situations in which inmate actions necessitated these uses of force.

Use of Force

The Department is focused on developing methods and strategies to manage incidents that could lead to use of force. Examples of mitigation and strategies to reduce the frequency of Use of Force incidents are:

- Crisis Intervention Techniques (CIT)

- Incident Command System (ICS)

Results of Use of Force Review Process

In FY 12-13 of 6,332 Use of Force Incidents, 40 or (0.6%) incidents were violation of policy

In FY 13-14 of 7,349 Use of Force Incidents, only 27 or (0.37%) incidents were violation of policy

Moving Forward

- Fill all security, medical, education and correctional supervision positions

- Comprehensive staff survey and development of accountability measures

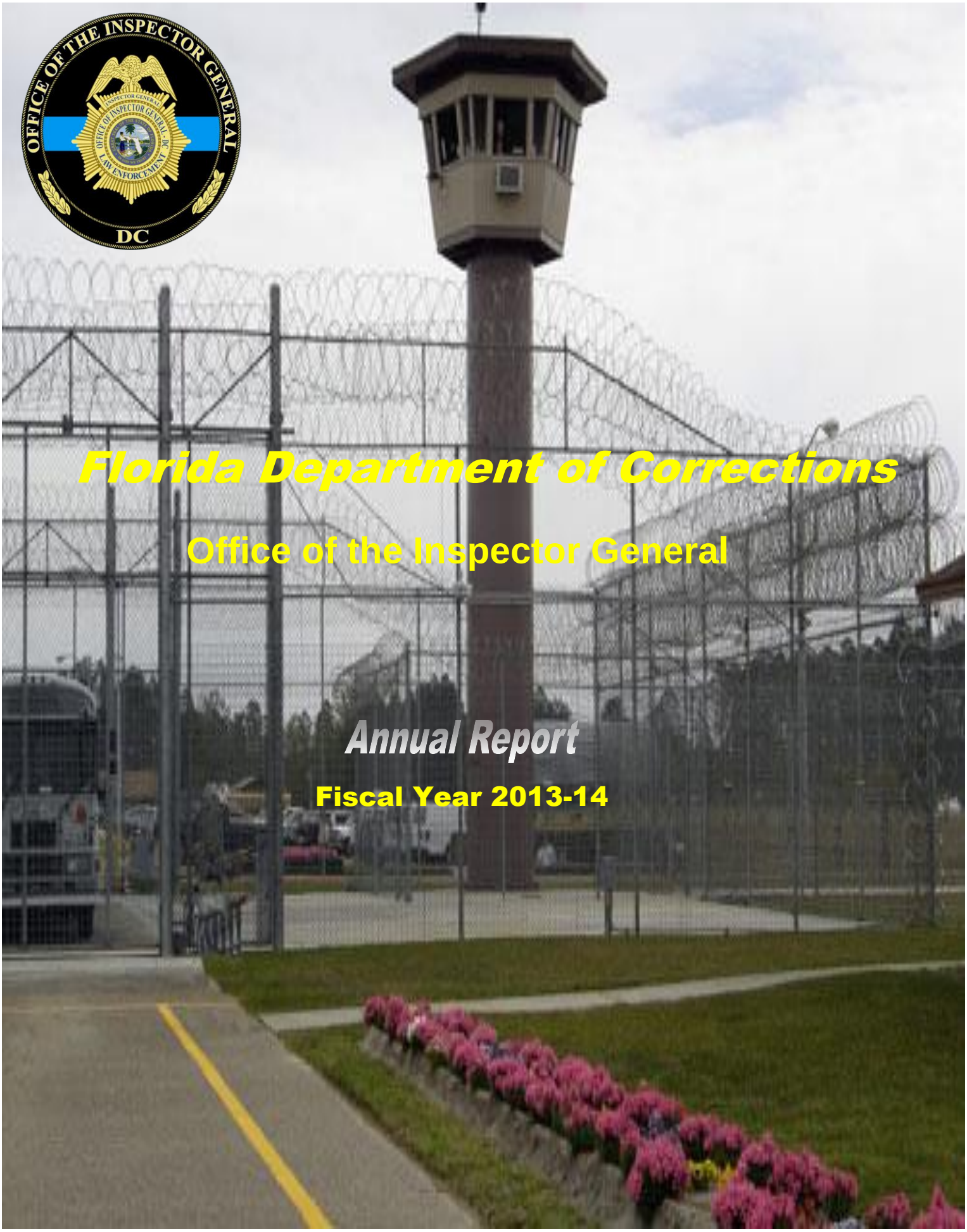
- Continue prison visits and hands-on assessments of Department facilities and staff

- Identify best management practices and process improvement

- Inform and educate all levels of staff of the behavioral and performance expectations of the Department

Thank You

Julie Jones, Secretary
(850) 717-3030



Florida Department of Corrections

Office of the Inspector General

Annual Report

Fiscal Year 2013-14

FLORIDA
DEPARTMENT of
CORRECTIONS

Changing Lives to
Ensure a Safer Florida

Governor
RICK SCOTT

Secretary
MICHAEL D. CREWS

501 South Calhoun Street, Tallahassee, FL 32399-2500

http://www.dc.state.fl.us

September 29, 2014

Michael D. Crews
Secretary
Florida Department of Corrections
501 South Calhoun Street
Tallahassee, Florida 32399-2500

Dear Secretary Crews:

I am pleased to present the Office of Inspector General (OIG) Annual Report for Fiscal Year 2013-14, provided pursuant to the mandate of Section 20.055(7), Florida Statutes. This report outlines the activities and accomplishments of the OIG for the fiscal year ending June 30, 2014.

A true measure of the value and services of the OIG can never be fully reflected in an annual report. The tangible results such as services performed, contracts audited, complaints referred, contract reviews and associated dollar impacts, and employees disciplined or convictions obtained as a result of an investigation can be readily reported. Our intangible services, however, including the deterrent effect of this office, are not always readily quantifiable in an annual report. This report documents the many activities that fall within the responsibility of this office and it reflects the high professional standards of each member of the OIG team.

I would like to take this opportunity to thank you for the support you have provided to this office. We look forward to continuing to work closely with you, your leadership team, and our fellow employees to promote economy, efficiency and effectiveness, and to help the Department accomplish its critical mission and initiatives in the months ahead. We remain committed to helping improve the operations and programs of the Department.

Please let me know if I may be of further assistance.

Respectfully submitted,

Jeffery T. Beasley
Inspector General

JTB/prs

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September 29, 2014

Melinda M. Miguel,
Chief Inspector General
Office of the Chief Inspector General
Room 2103 - The Capitol
Tallahassee, FL 32399-0001

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JTB/prs

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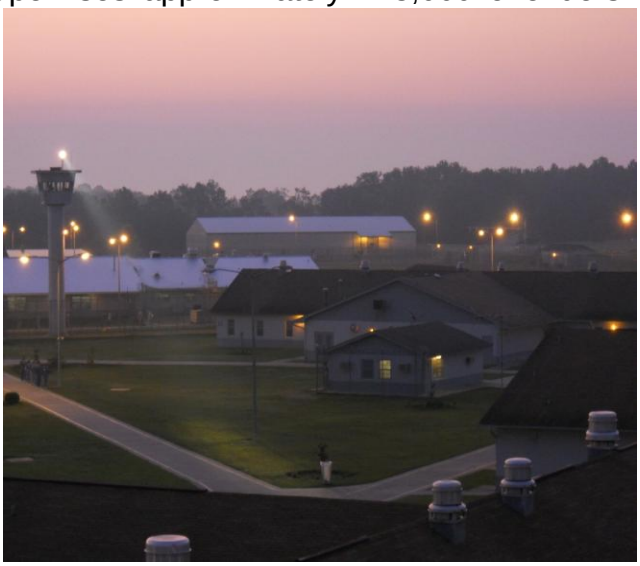
Department Background

As the nation's third-largest prison system, the Florida Department of Corrections fulfills a primary role in enhancing the safety of Florida residents. Through a network of 56 state prisons (including seven private prisons), road prisons, work camps and community-based facilities, the department manages incarceration and care for approximately 100,000 inmates. It also supervises approximately 143,000 offenders through 122 probation offices statewide. The department employs approximately 21,000 employees, the majority of whom are Correctional Officers or Correctional Probation Officers who carry out this public safety mandate 24 hours a day, 7 days a week, 365 days a year.



Purpose of this Annual Report

Section 20.055, Florida Statutes, requires the Inspector General submit to the agency head, and, for state agencies under the jurisdiction of the Governor, the Chief Inspector General no later than September 30 of each year, an annual report summarizing the activities during the preceding fiscal year. This report provides departmental staff and other interested parties with an overview of the Office of the Inspector General's activities as related to its mission.

Vision

A safe and efficient Florida correctional system.

Mission

Promote leadership to ensure accountability, integrity, and efficiency within the Florida Department of Corrections.

General Goals

To add value to the department by:

1. Continuously identifying department needs & priorities.
2. Identifying risk and threats that impact public safety.
3. Promoting innovative solutions to address the department's needs.
4. Providing timely, accurate and pertinent information to decision makers.

Accomplishments

During the last fiscal year, the Office of the Inspector General (OIG) launched multiple operational improvements designed to increase efficiency and effectiveness, and enhance public safety and accountability:

- Regional Evidence Control Areas: Fiscal year 2013-2014 marked the completion of a three year endeavor to establish 10 new Regional Evidence Control Areas, and a new Evidence, Property, and Contraband, Collection, Preservation, and Disposition Procedure, for the Department of Corrections and the Office of Inspector General. The Regional Evidence Control Areas, with an Automated Property and Evidence System, coupled with the Evidence, Property, and Contraband, Collection, Preservation, and Disposition Procedure, will continue to ensure the security and integrity of evidence and/or property collected for evidentiary value. The Inspector General's ten Regional Evidence Control Areas are managed by one Evidence Manager and twenty Inspectors performing duties as Evidence Custodians throughout the state. The following Regional Evidence Control Areas are open and operational: Santa Rosa CI, North Florida Reception Center, Wakulla CI, Mayo CI, Florida State Prison, Lowell CI, Tomoka CI, Zephyrhills CI, Hardee CI and the South Florida Reception Center.

- K-9/Interdiction: The OIG Canine Units participated in the Southern Coast Canine Annual Drug Detection Seminar and canine competition in late 2013. Competing against 120 other drug detection canine teams, Canine Inspector ELizair Mares and his canine partner Tina took the top honors in the drug detection category of the competition.

- Cellular Phone Forensic Lab: With support of agency leadership, the OIG took steps to establish a Cellular Phone Forensic Lab. Construction of the new lab has been completed and all of the pertinent equipment required to conduct analysis on contraband cellular devices has been purchased and installed. Once fully implemented, the lab will allow analysts to garner information to further investigations being worked by the OIG as well as other law enforcement agencies. Information retrieved from cellular phones, as well as other electronic devices, will be used to combat criminal activity being committed by inmates who are aided by associates and co-conspirators outside the prison system. The lab will enable the OIG to collect intelligence information that will be used by the

Office of Institutions to enhance the security within the institutions. The Tallahassee based lab has the capability to service the needs of the OIG and institutions throughout the state of Florida

Specific Areas of Responsibility

Primary services provided by the Office of the Inspector General include the following:

1. The Office of the Inspector General facilitates an **automated management information network** to keep designated personnel informed of events that occur on department property or concerning department staff, inmates, offenders, and other activity throughout the state. This information network:
   - provides an incident/event reporting system for all areas of the department, enabling early identification of problems and timely allocation of investigative and corrective resources;
   - collects statewide data for use by key personnel in developing strategies to address areas of concern;
   - provides timely flow of information to management and, through the Public Information Office, to the public; and
   - leads department efforts to maintain cooperative working relationships with Florida Department of Law Enforcement (FDLE) and other law enforcement agencies.
2. **Certified law enforcement and correctional inspectors** conduct criminal and administrative investigations relating to inmates, offenders, visitors, department and contract staff, and vendors. Inspectors:
   - take an active role in locating and coordinating the arrest of fugitives by working closely with the staff in the Fugitive Unit;
   - investigate crimes occurring on department property and coordinate with other law enforcement agencies and prosecutorial entities; and
   - conduct administrative investigations into allegations of misconduct by staff, contractors, inmates, and offenders.
3. The **Intelligence Unit** collects and analyzes data to identify trends, contraband introduction methods, officer safety issues, and gang and criminal activities in department facilities. This information and intelligence is used by senior management, other state and local law enforcement offices and agencies, the Federal Bureau of Investigation, and the Department of Homeland Security.

4. The **Contraband Interdiction Unit** assists the Office of Institutions in providing a safe environment for employees, inmates, and visitors by deterring the introduction of weapons, cell phones, narcotics and other contraband into correctional facilities. Interdiction teams:

    - conduct unannounced interdiction operations, including searches for weapons and narcotics, in both state and private correctional facilities; and
    - review contraband control processes at state correctional facilities for compliance with department policy and procedure.

5. **Inspectors** safeguard the integrity of the state's correctional system. The department has 85 sworn law enforcement officers on the OIG investigative staff, two certified law enforcement analysts, and 48 certified correctional officer inspectors. Inspectors:

    - conduct criminal and administrative investigations into internal affairs involving department operations, contracts, staff, inmates, visitors, and volunteers;
    - ensure compliance with department rules and procedures;
    - track and direct recapture of fugitives from justice;
    - operate contraband interdiction;
    - provide critical intelligence and gang information to law enforcement agencies across the state and nation;
    - coordinate investigative efforts with FDLE and other law enforcement agencies;
    - work closely with prosecutorial entities to facilitate the prosecution of criminal cases; and
    - coordinate department activities required by the **Florida Whistle-blower's Act.**

6. **Auditors** assess the efficiency and effectiveness of department programs and associated controls, measure compliance with laws and procedures, and serve to deter waste, fraud and abuse of department resources. Auditors:

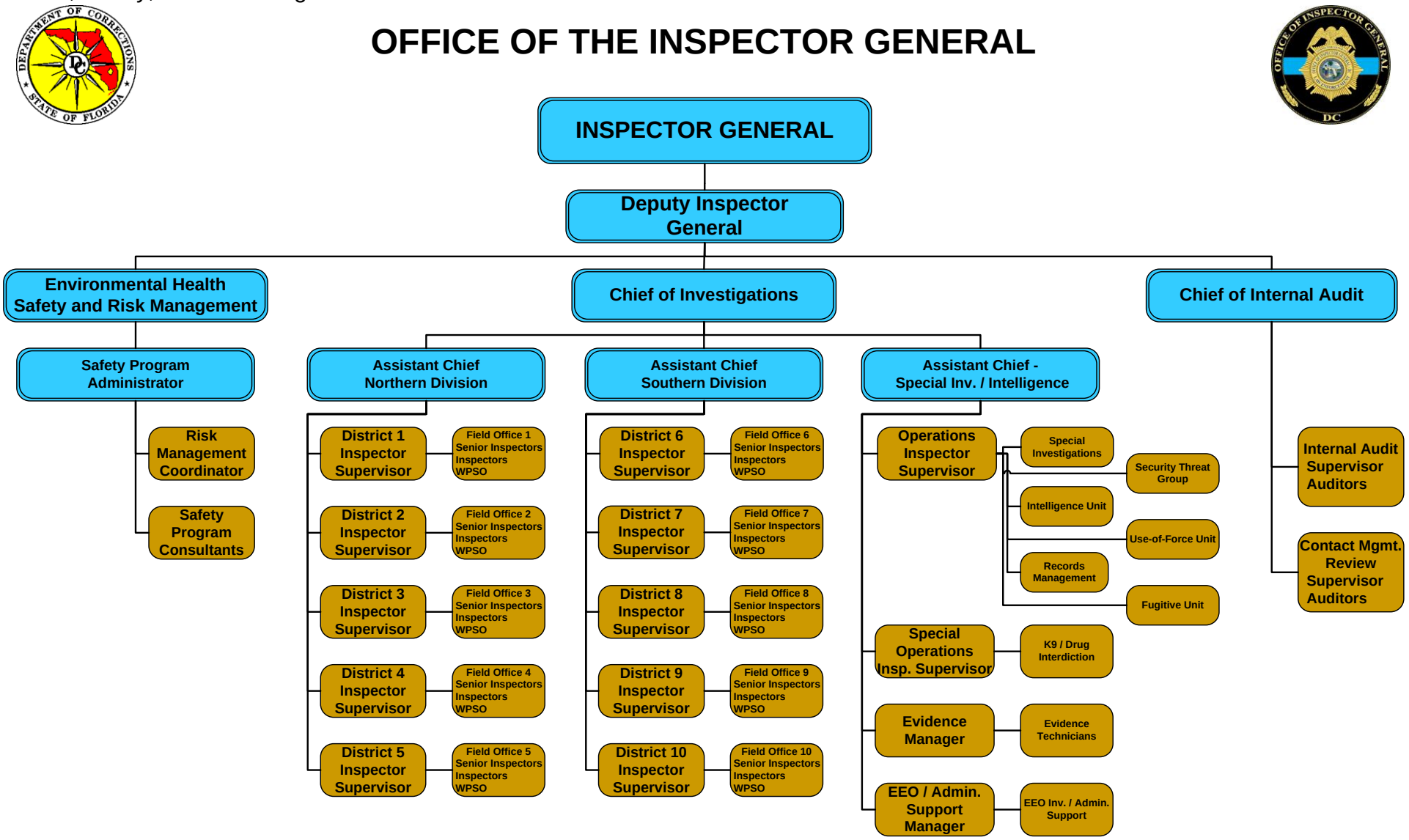
   - conduct compliance, performance and information technology audits in accordance with professional auditing standards and conduct reviews relating to department operations, contracts, staff, inmates, visitors and volunteers;
   - identify instances of fraud, abuse, and other deficiencies relating to department programs and operations, inform the Secretary of those conditions, recommend corrective action, and report on progress made in correcting deficiencies;
   - provide technical assistance with criminal and administrative investigations involving waste, fraud, or misappropriation of funds;
   - conduct contract management reviews to enhance accountability and oversight of the department's contracts for goods and services; and
   - serve as the department's liaison in coordinating audits and facilitating cooperation with external agencies including the Auditor General, Office of Program Policy Analysis and Government Accountability (OPPAGA), and FDLE.

7. **Environmental Health and Safety Officers** provide for the environmental health and safety of inmates, as well as department employees, volunteers and visitors. Areas of responsibility include:

   - accompanying state fire protection specialists of the Division of State Fire Marshal during annual fire safety surveys;
   - conducting annual fire, environmental health and Occupational Safety and Health Administration (OSHA)-related safety inspections of new, renovated and current institutions, followed by the on-site verification of corrected violations;
   - conducting the environmental health, safety and risk management portion of the operational review process that is conducted every two years at all major correctional facilities;
   - conducting training sessions for Loss Control Management to include accident investigation, general safety awareness, damaged or lost property coverage, and a review of workers' compensation issues; and
   - receiving and processing all Risk Management claims to include property damage, general liability, auto, boiler and machinery, and missing or damaged inmate property.

Office of the Inspector General Organizational Chart

The Office of the Inspector General (OIG) consists of two bureaus: Investigations and Internal Audit, and one unit: Environmental Health, Safety, & Risk Management.



Bureau of Investigations

Investigations

The Bureau of Investigations is responsible for conducting criminal and administrative investigations and providing oversight of all use of force incidents.

When completed, criminal investigations, for which probable cause exists that a crime has occurred, are referred to the appropriate prosecutorial entity for consideration for prosecution. When administrative investigations are completed, they are referred to management for appropriate follow-up action.

More than 59,403 incidents were reported and reviewed by the OIG during Fiscal Year 2013-14. Of the incidents reviewed by OIG, the table below represents the numbers and types of cases the Office of Inspector General investigated:

Type of Case	Total Number Assigned
Administrative Cases	920
Criminal Cases	1253
Death Investigations	260
Investigative Assists	101
Inquiries	5047
Inquires – Use of Force	1044
Use of Forces	7435
Whistle Blower Determinations	26
TOTAL	**16,086**

Source: IGIIS for 07/01/2013 to 06/30/2014.

Use of Force Unit

Established in 1999, the Use of Force Unit is responsible for reviewing all incidents involving the use of force at state and private correctional facilities, and those involving probation officers, to ensure compliance with established rules, procedures and statutes.

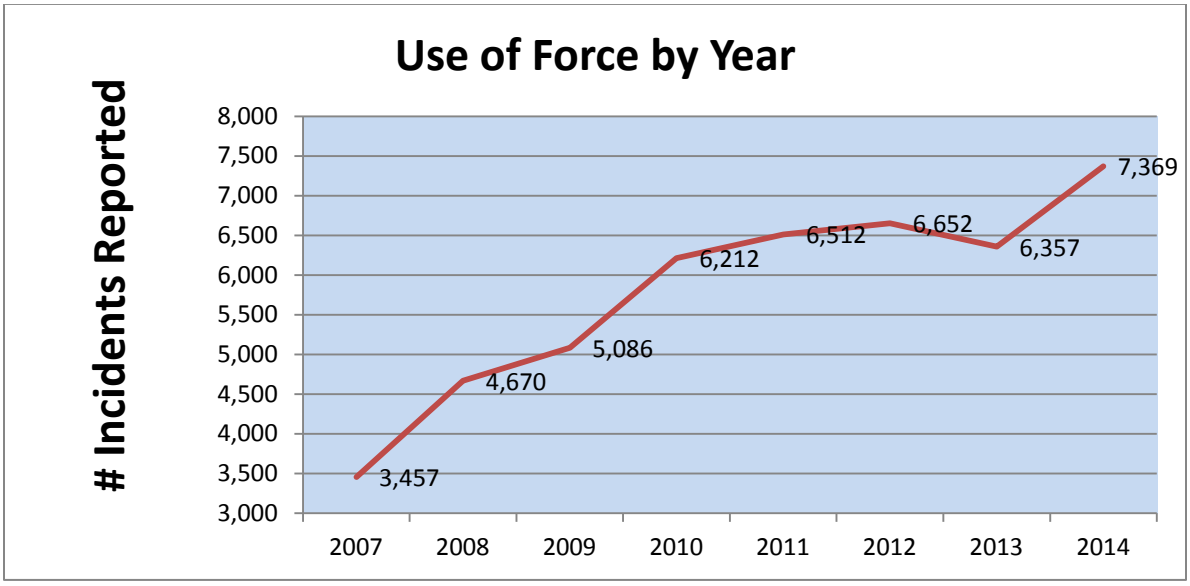
To accomplish this mission, the Use of Force Unit independently reviews and evaluates all use of force incident reports, associated documents and videotapes as required from each correctional facility or office. Evidence indicating possible procedural violations, inmate abuse, excessive/improper/unauthorized force, or battery by staff is referred to Investigations.

Uses of force are classified as major incidents whenever weapons, the chemical agent Ortho-Chlorobenzalmalononitrile “CS”, or electronic restraint devices are used, when force is used in a cell extraction, or when outside medical treatment is required for employees or inmates as a result of the use of force. Other physical contact with inmates, including use of the chemical agent Oleoresin Capsicum “OC”, is classified as minor. The following chart reflects use of force incidents reported to the unit in Fiscal Year 2013-14.

Classification	Reason Force Was Used	Number
27A	Self Defense	733
27B	Escape/Recapture	4
27C	Prevent Escape During Transport	3
27D	Prevent Property Damage	144
27E	Quell a Disturbance	2,402
27F	Physical Resistance to a Lawful Command	2,831
27G	Prevent Suicide	935
27H	Restrain Inmate for Medical Treatment	48
27I	Cell Extraction	215
27J	Mental Health Restraint	9
27K	Probation & Parole Handcuffing	0
27O	Other	45
	TOTAL	**7,369**

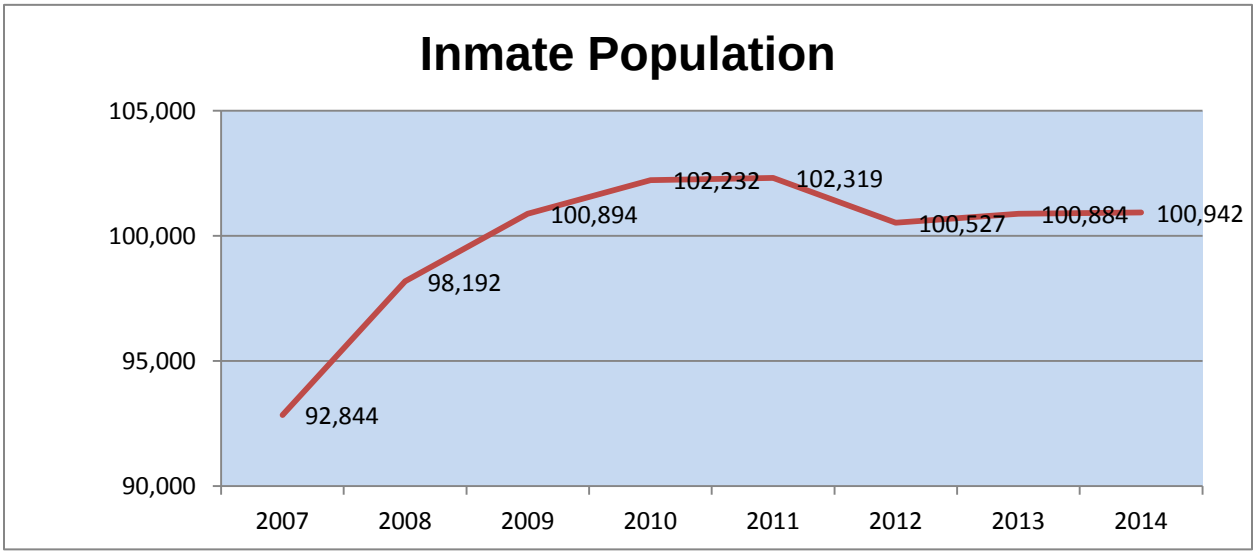
Source: MINS for 07/01/2013 to 06/30/2014

The number of use of force incidents reported increased between 2007 and 2012, rising more than 90% in five years, along with the increase in inmate population. The number of use of force incidents decreased by 4.4% in Fiscal Year 2012-13. *The reduction in the use of force incidents was a result of change in Florida Administrative Code (F.A.C.) Effective December 16, 2012, Chapter 33-602-210, F.A.C. no longer required four/five point medical restraints without force to be reported as a use of force incident.*



Source: MINS

As illustrated by these two charts, use of force incidents increased approximately 16% in the Fiscal Year 2013-14, while the inmate population increased less than 1% in the same period.



Source: Research and Data Analysis.

Intelligence Unit

The Intelligence Unit collects, analyzes, and utilizes data and information from multiple internal agency and external sources, which provide information to support investigative operations and to identify trends, contraband introduction methods, officer safety issues, gang activities, and criminal activity on department property. Programmatic and investigative statistical information, as requested, is also provided to senior management. The Intelligence Unit provides information to outside law enforcement upon request and, via the Florida Fusion Center, serves as liaison with the Federal Bureau of Investigation (FBI) and the Department of Homeland Security. Two Intelligence Unit members are FDLE certified crime analysts.

The Intelligence Unit is responsible for preparation of information and intelligence products on varied topics, including investigative caseload analysis, drug seizure data analysis, cellular telephone, and other contraband seizure analysis. Performance measures and monthly reporting data are maintained and prepared by the unit in addition to publishing the monthly Intelligence Bulletin.

The Corrections Intelligence Initiative (CII) is a program sponsored by the FBI designed to assist correctional facilities in their efforts to detect, deter, and disrupt efforts by terrorist or extremist groups who are trying to radicalize or recruit among inmate populations. The CII facilitates the flow of domestic and homeland security information to the FBI. The Intelligence Unit has been responsible for the creation of intelligence products shared nationally via the Department of Homeland Security and for reporting in *e*Guardian, the FBI national intelligence sharing system. Two Intelligence Unit members are ad hoc members of the North Florida Joint Terrorism Task Force and the North Florida Regional Domestic Security Task Force. To further support the CII, the OIG dedicates one full time position to the Joint Terrorism Task Force FBI's Miami field division.

Florida Fusion Center

The Florida Fusion Center, located in Tallahassee, Florida, serves as Florida's primary fusion center responsible for the gathering, processing, analyzing and disseminating terrorism, law enforcement, and homeland security information.

Intelligence Liaison Officers (ILOs) are vetted to participate in the fusion process and hold the appropriate security clearance with the Department of Homeland Security. The OIG has three liaison officers with the Florida Fusion Center - two from the Intelligence Unit and one from the Security Threat Group/Gang Unit. The Intelligence Unit represents the department at the Florida Fusion Center and serves as primary point of contact for the Corrections Intelligence Initiative.

Fugitive Unit

The Fugitive Unit, created in January 2007, is tasked to protect Florida's citizens by investigating escapes from State and private facilities. The unit tracks and locates the fugitive in question and coordinates with law enforcement to return the fugitive to custody. The Fugitive Unit provides criminal investigative assistance to other law enforcement agencies who may be seeking fugitives who have ties to Florida.

In 2008, the Fugitive Unit partnered with the FDLE as part of a collaborative initiative. Together these departments track down the most violent of Florida's fugitives and return them to custody. In 2009, the cooperative association with FDLE blossomed into an end-of-the-year holiday campaign designated the "12 Days of Fugitives." Florida Representative Connie Mack recognized the successful new initiative from the floor of the House of Representatives, commending the multi-agency project for its innovation. The long-term partnership with FDLE continues to produce positive results for the state.

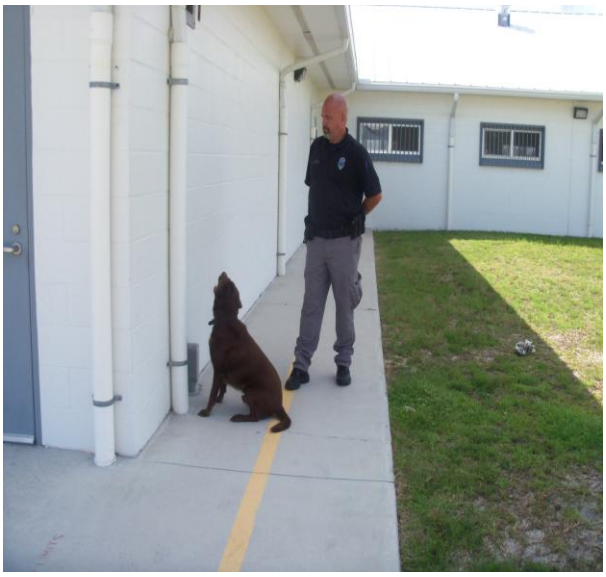
In June 2012, the department joined with the Florida Association of Crime Stoppers, the Office of the Attorney General, and the FDLE to make it easier for inmates, probationers, and members of the public to anonymously provide crime tip information to law enforcement. Prominent posters displaying the toll-free number to the Florida Association of Crime Stoppers are located in each correctional facility and probation office. The department also created a new public-access web page to highlight Florida's "Ten Most Wanted" felons and has posted the images and names of the worst of Florida's fugitives and absconders. The Florida Association of Crime Stoppers displays these same felons on public billboards and in other types of print and electronic media throughout Florida.

In the Fall of 2013, the Office of the Inspector General dedicated a full-time inspector position to the United States Marshal Service. As a Special Deputy US Marshal, the inspector has become an integral part of the Florida Regional Fugitive Task Force, training with them and working side-by-side to return violent felons and sex offenders to custody.

During Fiscal Year 2013-14, there were two attempted and foiled escapes from Florida correctional institutions; there were two successful escapes from a secure perimeter as a result of fraudulent court documents mailed from the Orange County Clerk of Court. The two inmates were captured without incident. Security procedures have been instituted to detect and prevent such escape attempts.

During Fiscal Year 2013-14, the Fugitive Unit cleared 115 fugitive cases and provided investigative support to outside law enforcement agencies (at national, state and local levels) in 41 criminal cases. Since 2007, the Fugitive Unit has facilitated the recapture of 1,246 fugitives nationwide.

Contraband Interdiction/Narcotic Canine Unit



The Contraband Interdiction Unit promotes a safer environment for employees, inmates, and visitors by detecting and discouraging the introduction of contraband such as weapons, cellular telephones, and narcotics. Interdiction inspectors conduct unannounced contraband searches with assistance from certified narcotic canine teams. During the interdictions, employees, visitors, volunteers, inmates, vehicles, and facility grounds are searched for contraband. Random interdiction operations and canine sweeps are conducted at all state and private prisons.

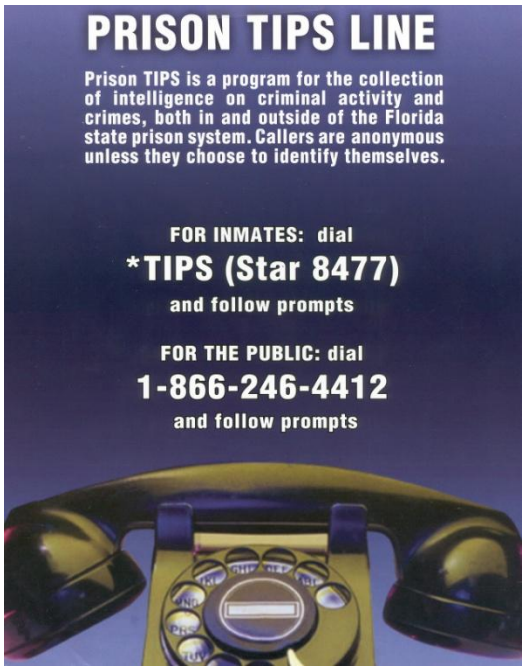
The OIG operates 20 full-time canine teams comprised of 24 inspectors strategically located throughout the state. The teams participate in interdiction and search operations at prisons and other facilities statewide and provide narcotic canine support for other agencies, including the Federal Bureau of Prisons and local law enforcement agencies. The canine teams also work closely with institutional inspectors and provide investigative support.

The following table summarizes arrests and seizures generated by the OIG's canine teams and interdiction operations during Fiscal Year 2013-14.

K9/ Drug Interdiction Team Operations	FY 2013-14
Arrests:	
Employees	4
Visitors	26
Inmates	11
Contraband Seized:	
Alcohol (gallons)	
Commercial	21.67
Homemade	78.31
Drugs (grams)	
Marijuana	2342.37
Synthetic Cannabinoid	13360.65
Cocaine	54.3
Other	1001
Prescription drugs (dosage units)	1142
Weapons, Cell Phones, Money	
Firearms (in vehicles on state property)	15
Ammunition (rounds, in vehicles)	1099
Knives/sharps (entering or inside institution)	477
Cell phones or parts/accessories	1783
Cash (excessive or contraband)	$5707

Source: K9/ Drug Interdiction Unit

Prison TIPS



The Intelligence Unit oversees the prison "TIPS" line which was accessed over 18,000 times this fiscal year. Phone calls made to the "TIPS" line are reviewed daily and the information provided is used to collect criminal intelligence on unsolved or ongoing criminal activity, both inside and outside of the department. The "TIPS" line also serves as the portal for Prison Rape Elimination Act (PREA) and fraud, waste, and abuse calls. Inmates, probationers, or any other callers that may have knowledge of these types of activities can use "TIPS" as an anonymous method to provide this information.

The "TIPS" line can be accessed from inmate phones within all department facilities or by a toll-free number (1-866-246-4412) from phones outside the facilities. This fiscal year the TIPS system was enhanced to allow access for hearing impaired inmates utilizing TTY technology. Information provided by callers is reviewed and forwarded to the appropriate department staff or to the law enforcement agency having jurisdiction over the reported activity.

Callers have the option of establishing a voice mailbox, accessed by a unique pass code, which is provided upon the callers' request. This provides a mechanism to exchange messages and information from the caller and Office of the Inspector General on the status of the information provided.

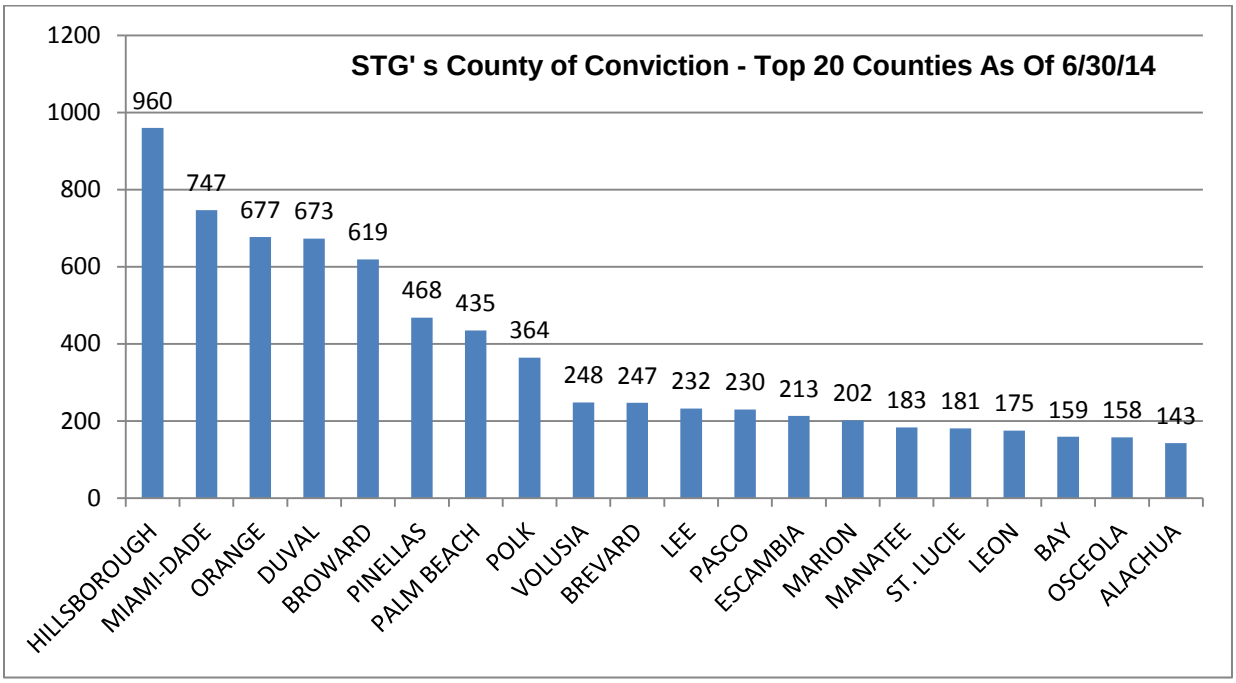
Security Threat Intelligence Unit

The Inspector General's Security Threat Intelligence Unit (STIU) collects, analyzes, and distributes intelligence related to criminal gang activity both within and outside the state correctional system. The STIU assists institutional staff by reviewing gang-related incidents as they occur in prison settings and making recommendations for relocating or restricting inmates based on their role in the incident.

The STIU not only assists local, county, state, and federal law enforcement agencies with identifying gang members, but it also provides training to the community. In the past year, the STIU has conducted over 10 trainings to schools, local community town hall meetings, and law enforcement agencies.

As of June 30, 2014, 9,139 of the department's 100,942 inmates (9%) were identified as gang members. Another 2,195 of the department's probationers have been identified as gang members.

Each year, gang members are sentenced to the department's custody from each of Florida's 67 counties. The top 20 counties as of June 30, 2014, are depicted in the table below:



Source: Security Threat Intelligence Unit

The STIU reviewed 54,000 incident reports in which over 7,000 of those incidents had an STIU member involved in some manner. In the last year, the STIU received over 200 emails and phone calls per month from department staff, law enforcement, college students, and concerned parents regarding gangs.

During the last fiscal year, the STIU sent out more than 2,200 notices to law enforcement agencies, informing them of pending releases of gang members from department custody back into their communities. The STIU also notifies law enforcement agencies monthly of gang members who are serving terms of probation in their jurisdictions.

Some gang tattoos and graffiti that identity gang members are displayed below:

Latin King tattoo

Satan Disciples graffiti on the back of inmate id card

EEO Investigative Unit

The Inspector General's Equal Employment Opportunity (EEO) Investigative Unit is responsible for examining alleged violations of Title VII of the Civil Rights Act, Chapter 60L-36.004, F.A.C. and Chapter 110, Florida Statutes. EEO complaints are received through several channels, including the department's internal complaint procedure, the Florida Commission on Human Relations (FCHR), and the Equal Employment Opportunity Commission (EEOC). The EEO Investigative Unit is staffed by an Operations & Consultant Manager. EEO complaints are referred to appropriate staff for investigation.

During Fiscal Year 2013-14, 101 EEO complaints were investigated originating from the following sources:

FY 2012-13 EEO Complaints Filed	
Number	**Complaint Source**
29	Internal Department Process (formal and informal)
39	FCHR – includes whistle blowers
33	EEOC

Source: Civil Rights/EEO

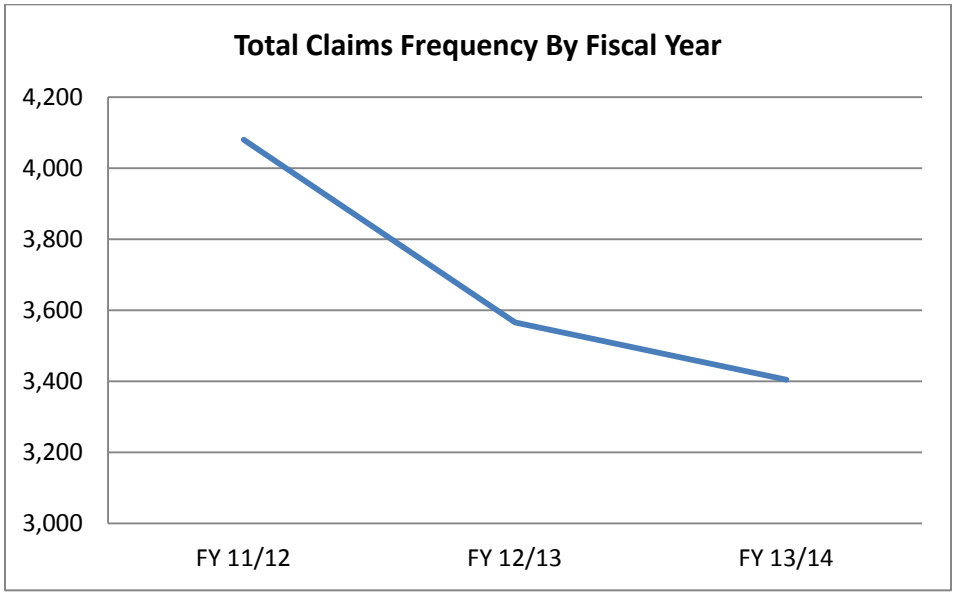
Whistle-blower Unit

The Whistle-blower Unit is the designated liaison between the Chief Inspector General's Office (CIG) and the OIG. The Whistle-blower Unit coordinates and conducts Whistle-blower investigations pursuant to Florida law. During Fiscal Year 2013-14, the Whistle-blower Unit processed 26 Whistle-blower cases.

Environmental Health, Safety, & Risk Management

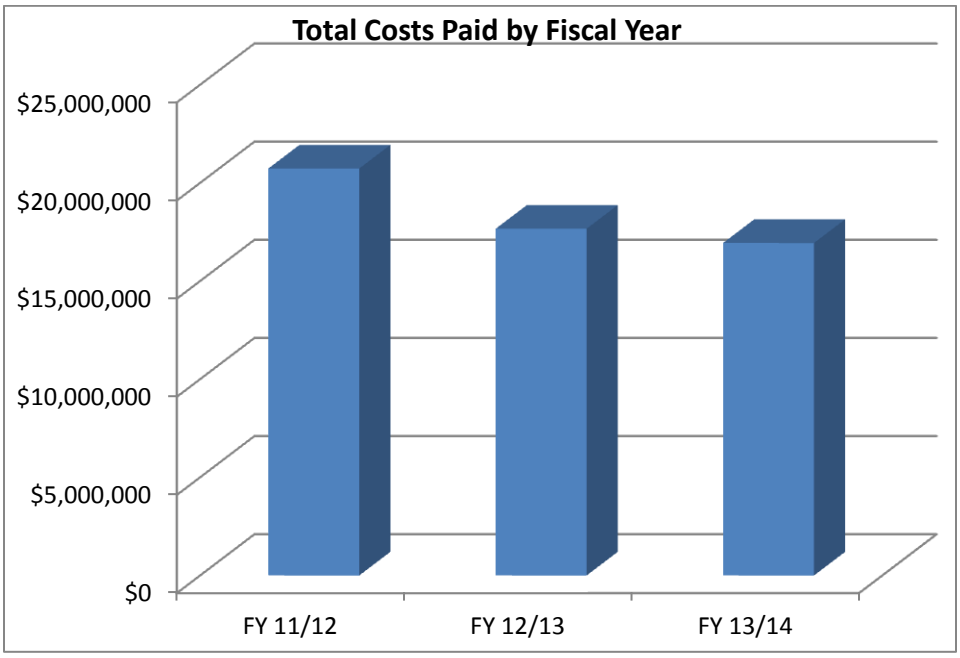
Due to its unique mission, the Department of Corrections must provide for the environmental health and safety of inmates, as well as its own employees, volunteers, and visitors. The department has a formal risk management program on file with the Department of Financial Services, Division of Risk Management. The program is implemented pursuant to the department's Environmental Health and Safety Manual. The goal of the Environmental Health and Safety Program is to reduce the frequency and severity of accidents through training, administrative guidelines, and aggressive promotion of safe work practices. Adherence to established health and safety guidelines is one of the most important responsibilities of every employee and inmate.

The following table displays claims reported for the last three fiscal years. In Fiscal Year 2013-14, the department reduced total claims reported by 5% compared to the previous fiscal year.



Source: Environmental Health, Safety, & Risk Management

The total paid costs (Worker's Compensation costs, General Liability costs, Federal Civil Rights costs, Automobile Liability costs, and Malpractice costs) for the last three fiscal years is displayed below and demonstrates a decrease in total costs from the previous fiscal year:



Source: Environmental Health, Safety, & Risk Management

Bureau of Internal Audit

Mission

The mission of the Bureau of Internal Audit is to support the Secretary and the department by ensuring:

1. established objectives and goals are met;
2. resources are used consistent with laws, regulations, and policies;
3. resources are safeguarded against waste, loss, and misuse; and
4. reliable data is obtained, maintained, and fully disclosed.

Goals

The Bureau of Internal Audit's primary purpose is to proactively assist management in successfully meeting the department's mission and established objectives. To meet its purpose, the Bureau of Internal Audit has four key goals:

1. perform quality audits, reviews, studies, and investigations;
2. report results to management in a timely manner;
3. ensure department resources are used efficiently; and
4. provide adequate audit/review coverage to mitigate risks.

Bureau Organization and Responsibilities

The Bureau of Internal Audit comprises two sections: (1) Internal Audit and (2) Contract Management Review. These sections report to the Bureau Chief, a Certified Internal Auditor, who functions as the Director of Auditing. The Bureau of Internal Audit conducts compliance, performance, and information technology audits and contract reviews pursuant to section 20.055, Florida Statutes. Audits are conducted in accordance with the current *International Standards for the Professional Practice of Internal Auditing* published by the Institute of Internal Auditors (IIA).

The internal audit staff possesses accounting and auditing experience, including information technology auditing experience. Staff members are required to maintain professional proficiency through continuing education and training. Staff are active in professional associations, the Institute of Internal Auditors (IIA), Information Systems Audit and Control Association (ISACA), the American Institute of Certified Public Accountants, the Florida Chapter of the National Association of Inspectors General, and the Association of Government Accountants.

Internal Audit Section

This section employs an audit supervisor and four auditors who perform compliance, performance, and information technology audits and reviews. Staff certifications include a Certified Internal Auditor (CIA), a Certified Public Accountant (CPA), and a Certified Government Auditing Professional (CGAP).

Projects Completed by Compliance/Performance/IT Section

During Fiscal Year 2013-14, the Internal Audit section completed sixteen audits, eight follow-up audits, and three reviews as listed in the following table by report date.

FY 2013-14 Audit Reports and Reviews		
Report Number	**Project Title**	**Report Date**
A13034F	Follow-up of Auditor General's Report #2013-074	7/17/13
A13012F	Follow-up of Employee Benefit Trust Fund Audit	8/1/13
A13022F	Follow-up of Audit of Offender Supervision	8/2/13
A13029	Inmate Release Gratuity Audit – Suwannee CI	8/15/13
A13015	Inmate Release Gratuity Audit – Baker CI	8/16/13
A13008	Data Backup and Recovery Audit	8/29/13
R13019	Quality Assessment Review	9/12/13
A14007F	Follow-up of Auditor General's Report #2013-133	9/13/13
A13030	Employee Benefit Trust Fund Audit – Taylor CI	9/27/13
A13024F	Follow-up of Audit of Phoenix Houses of Florida, Inc	10/3/13
A13009	Audit of Entering/Exiting DC Institutions	10/3/13
A13032	Inmate Release Gratuity Audit – Jefferson CI	10/17/13
A13033	Employee Benefit Trust Fund Audit – Jefferson CI	11/13/13
A14008F	Follow-up of Audit of Inmate Gain Time	12/11/13
A14009F	Follow-up of Audit of Inmate Grievances	1/24/14
R14013	Review of Dade CI Employee Benefit Trust Fund	2/18/14
A14001	Audit of Quarterly Performance Meas. Reported to the EOG	2/26/14
A14002	Audit of Department of Corrections Purchasing Card	3/5/14
A14004	Audit of Arsenal and Ready Room Equipment	3/12/14
A14003	Audit of Pharmacy Drug Inventory	3/25/14
A14014	Employee Benefit Trust Fund Audit – Jackson CI	4/10/14
A14011	Audit of Information Technology (IT) Mobile Computing	6/10/14
A14010	Audit of DC Reception Classification Process/Inmate Orientation	6/16/14
A14019F	Follow-up of Auditor General's Report #2014-066	6/16/14
A14018	Employee Benefit Trust Fund Audit – Calhoun CI	6/18/14
A14012	Audit of Inmate Drug Testing	6/19/14
R14015	Review of Inspector General Correspondence	6/27/14

Source: Bureau of Internal Audit

Selected Bureau Reports with System-Wide Impact

The Bureau of Internal Audit views its audit mandate as an opportunity to not only identify site specific deficiencies and problems with statewide impact, but also to identify areas that are well designed and are meeting management's goals. Reports with statewide impact conducted by the Bureau of Internal Audit in Fiscal Year 2013-14 included:

Audit of Department of Corrections (DC) Purchasing Card Program

Audit staff found, in general, the purchasing card program is operating in accordance with applicable laws, rules, and regulations and internal controls exist that adequately prevent, deter, and detect fraud. The purchasing card program has established transaction limits for cardholders, purchases are made from an approved vendor list, and monthly reconciliations are performed on all purchasing card transactions. Audit staff also found that at the time of fieldwork, all purchasing cards had been deactivated for terminated employees. Finally, the transactions selected for review by audit staff were in compliance with the applicable purchasing rules. However, one issue was identified that warranted management's attention:

Finding: The Bureau of Procurement and Supply has not conducted post-audits on purchasing card transactions since taking over the program in June 2013.

Audit of DC Reception Classification Process/Inmate Orientation

Audit staff found, in general, the department is in compliance with applicable laws, rules, policies, and procedures pertaining to the inmate orientation and inmate reception processes. Furthermore, internal controls exist to adequately detect, deter and prevent fraud. Of note were certain aspects of the processes that directly relate to the mission and vision of the department. Specifically, all inmates included in the sample were subject to educational testing, health screenings, and substance abuse assessments. In addition, PREA screenings were conducted in a timely manner. Also, the Biometric Identification System used to fingerprint incoming inmates was always utilized. Finally, inmate orientation materials such as videos and handbooks were on hand (in English and Spanish) at the 5 reception centers. However, audit staff identified one issue that warrants management's attention to ensure compliance with all aspects of the procedure and Florida law:

Finding: Canteen privileges were not always suspended for non-alien inmates that either refused or could not provide a valid social security number; and when social security numbers were provided, they were not always recorded in the Offender Based Information System (OBIS) and the Computer Assisted Reception Process (CARP).

Contract Management Review Section

The Contract Management Review (CMR) Section employs an audit supervisor and three auditors. Staff certifications include one staff member who is a Certified Internal

Auditor (CIA) and a Certified Inspector General Auditor (CIGA).

In Fiscal Year 2013-14, the CMR section completed twelve reviews. The review reports are listed by report date:

FY 2013-14 CMR Reports and Reviews		
Report Number	**Project Title**	**Report Date**
CMR13002	Capital One & Florida Power and Light	8/9/2013
CMR13004	Pride Enterprises	11/26/2013
CMR14002	Simplex Grinnell LP	12/19/2013
CMR14004	Tallahassee Community College	1/14/2014
CMR14008F	Bridges of America--Bradenton WRC Follow-Up	1/17/2014
CMR14007F	SMA Behavioral Health Follow-Up	2/6/2014
CMR14003	Time For Freedom, Inc	2/13/2014
CMR14006	Non-Secure Programs, Inc.	2/20/2014
CMR14009	Community Education Center	3/19/2014
CMR14005	Unlimited Path of Central Florida	6/10/2014
CMR14010	Shisa House West	6/26/2014
CMR14012	The Thoroughbred Foundation	6/26/2014

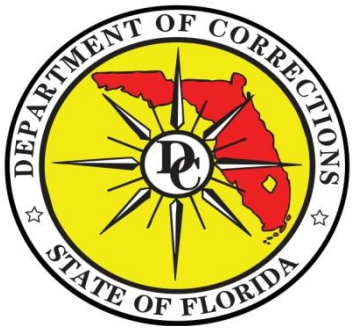
Source: Bureau of Internal Audit

Review of Time for Freedom, Inc.

Time for Freedom, Inc. provides eligible inmates with substance abuse and work release transitional re-entry services. The review indicated that overall service was rendered as required by the contract and invoices were in accordance with the contract terms and well documented. However, deficiencies were identified with regards to inmate employment programming, contract monitoring, inmate case files, and documenting food substitutions.

Review of Non-Secure Programs, Inc.

Non-Secure Programs, Inc. provides qualified staff to operate a probation and restitution center in Orange County, Florida. Services include housing, meals, employment, and program services for offenders on community supervision with the department and released inmates in need of transition services. The review focused on contract monitoring efforts by the department's contract management staff. Overall, contract management staff met monitoring requirements. However, the sample results and parameters used were not always documented during monitoring.



Jeffery T. Beasley
Inspector General

Ken Sumpter
Deputy Inspector General

(Vacant)
Chief of Investigations

Paul Strickland
Chief of Internal Audit

Patricia Perkins
(Acting) Operations & Management Consultant Manager

Florida Department of Corrections
Office of Inspector General
501 South Calhoun Street
Tallahassee, Florida 32399-2500
(850) 488-9265

Tab 1

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/20/15
Meeting Date

Topic Department of Corrections Update

Bill Number N/A *(if applicable)*

Name Julie Jones

Amendment Barcode N/A *(if applicable)*

Job Title Secretary, DOC

Address 501 S. Calhoun St.
Street

Phone 850-717-3030

Tallahassee FL 32399
City *State* *Zip*

E-mail jones.julie@mail.dc.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Representing Department of Corrections

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

TAB 1

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/20/15
Meeting Date

Mental Health Questions

Spoke
Bill Number (if applicable)

Topic Corrections Update

Amendment Barcode (if applicable)

Name Dean Autderheide

Job Title Director, Mental Heath Services

Address 501 S. Calhoun St
Street

Tallahassee FL 32399
City *State* *Zip*

Phone 850-717-3030

Email autderheide.dean@mail.dc.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

TC6 1

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/20/15
Meeting Date

DID NOT SPEAK mtg out of time

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic DOC - ABUSE

Name ELSA WHITLOCK

Job Title PARALEGAL

Address 610 N. DUVAL ST
Street

Phone 224-5556

Email e.d.whit@iv.net

City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing SELF

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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This form is part of the public record for this meeting.

S-001 (10/14/14)

State Correctional Oversight Entities

Florida Senate Committee on Criminal Justice

Matthew Moncrief, Senior Legislative Analyst

January 20, 2015

State Correctional Oversight Entities

- OPPAGA reviewed correctional oversight entities, including boards, commissions, and councils, in other states
  - Structure
    - Membership and meeting frequency
  - Powers and duties
    - Personnel decisions
    - Budget authority
    - Ability to make other changes to the correctional agency
- Role of Correctional Ombudsman
  - Investigate complaints
  - Unannounced facility visits and full access to documents

Oversight Entity Structure

- Membership
  - Ranged from 3 to 23 members; most had fewer than 10
  - In some cases, members are identified by role
  - Most appointed by governor, sometimes with advice or consent of senate
  - Terms ranged from 3 to 7 years
- Meeting Frequency
  - Ranged from once per quarter to once per month; most commonly once per month

Oversight Entity Powers and Duties

- Personnel decisions
  - Some recommend, appoint, or terminate the agency head or other key positions
- Budget authority
  - Most review or approve agency budget and budget requests
- Creates, reviews, or approves other correctional policies
  - May be only advisory

Management and Accountability Powers of Oversight Entities Varied

- Texas Board of Criminal Justice
  - 9 members appointed by governor for staggered, 6-year terms
  - Required to meet once every quarter, generally meets every other month
  - Hiring and firing authority for some department positions, including executive director
  - Approves the budget and the legislative appropriations request
  - Approves amendments proposed by the department to operational policies on the use of force, offender access to courts, offender visitation, and other inmate issues

Other States with Oversight Entities

- Arkansas Board of Corrections
- Delaware Council on Correction
- Georgia Board of Corrections
- Idaho Board of Correction
- Iowa Board of Corrections
- Kentucky State Corrections Commission
- New York State Commission of Correction
- Oklahoma Board of Corrections
- South Dakota Corrections Commission

Correctional Oversight in Florida

- Florida Corrections Commission (1994-2004)
  - Housed within DOC, but independent
  - Charged with recommending major correctional policies and improvements to the Governor and assuring that approved policies were properly executed
- Correctional Medical Authority (CMA)
  - Housed in Governor's Office; conducts health care surveys at each Florida prison every 3 years
  - Survey reports are followed by monitoring of corrective action plans until facilities comply

Role of Correctional Ombudsman

- Power to investigate and resolve complaints
  - Concerns for health or safety
  - Violations of specific laws, rules, or written policies
- Freedom of access
  - Entrance to inspect department premises
  - Access to all department information, records, and documents

3 States with Correctional Ombudsman

- Georgia Department of Corrections Offender Ombudsman and Inmate Affairs Unit
  - Department of Corrections
- Indiana Department of Correction Ombudsman Bureau
  - Department of Administration
- Michigan Office of Legislative Corrections Ombudsman
  - Legislature

Questions?

Contact Information

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Claire K. Mazur
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State Correctional Oversight Entities

State Correctional Oversight Entity	Authorization	Membership	Meeting Frequency	Powers and Duties	Personnel Decisions	Budget Authority	Ability to Make Changes to the Correctional Agency
Arkansas Board of Corrections	Amendment 33, *Constitution of the State of Arkansas of 1874*	Seven members, including five citizen members, the chair of the Parole Board, and one member of a criminal justice faculty who is employed at any four-year university in Arkansas, are appointed by the governor for staggered, seven-year terms.	The board is required by code to meet at least quarterly, but usually meets once a month and as needed.	The board oversees the Department of Correction, the Department of Community Correction, and the Correctional School System. The board approves all of the administrative regulations that govern these agencies and approves the agencies' organizational charts.	The board has hiring and firing authority over the directors of the Department of Correction, the Department of Community Correction, and the Correctional School System.	The agencies have to submit their budgets to the board for approval.	The board has general supervisory power and control over the department and thus oversees all policy and operational changes.
Delaware Council on Correction	Title 29, SubSection 8905, *Delaware Code*	The council is composed of 11 members. At least five, but no more than six, members of the council must be affiliated with one of the major political parties and at least four, but no more than five, of the newly appointed members must be affiliated with the other major political party. Ten members are appointed for three-year terms by the governor. Additionally, the governor appoints a chairperson to serve at his or her pleasure.	The council usually meets 10 times per year.	The council serves in an advisory capacity to the commissioner of correction and considers matters relating to the development and progress of the correctional system. The council also considers other matters that may be referred to it by the governor, the commissioner, and the chief of the Bureau of Adult Correction. The council may study, research, plan, and advise the commissioner and the governor on matters it deems appropriate to enable the department to function in the best manner.	No.	No.	The council can recommend changes to the Department of Correction, but the department doesn't have to act on the council's recommendations.
Georgia Board of Corrections	Section 42-2-1, *Georgia Code Annotated*	The board is composed of 19 members, 1 from each congressional district in the state and 5 members from the state at large. The governor appoints all members, subject to the consent of the state senate, to staggered five-year terms.	The board is required by code to meet monthly in the office of the Department of Corrections' commissioner. Additionally, special meetings may be held by the call of the chairman of the Board of Corrections or by the commissioner.	The board develops rules governing the conduct and welfare of employees under its authority and the assignment, housing, feeding, clothing, treatment, discipline, rehabilitation, training, and hospitalization of all offenders coming under its custody.	The governor recommends a commissioner for the Department of Corrections and the board approves/appoints the commissioner. However, the board cannot hire, terminate, or impose sanctions on other Department of Corrections employees.	No.	While the board has significant policy authority, it is volunteer-based and doesn't become highly involved in policy issues. The board approves resolutions and real estate transactions.

State Correctional Oversight Entity	Authorization	Membership	Meeting Frequency	Powers and Duties	Personnel Decisions	Budget Authority	Ability to Make Changes to the Correctional Agency
Idaho Board of Correction	IDAPA 06.01.01, *Idaho Administrative Code*	The board is composed of three members appointed by the governor. The governor appoints at least one member of a different political party. Board members are appointed to six-year terms.	The board generally meets monthly, but may sometimes only meet quarterly. The chairman can call a meeting at any time, but doesn't exercise this option often.	The board has control, direction, and management of all correctional facilities and property used in connection with correctional facilities. The board also makes and adopts rules governing correctional facilities. The director of the Department of Correction assumes all the authority, powers, functions, and duties as may be delegated by the board.	The board appoints and can terminate the director of the Department of Correction. Other personnel decisions could be initiated by the board, but traditionally the board has assigned those duties to the director.	No. The board reviews the budget, and may make recommendations, but the budget is created by agency staff.	The board has a role in agency decision making. For example, when the Department of Correction was restructured from two divisions to four, the department director conferred with the board but made the recommendations and decisions.
Iowa Board of Corrections	Section 904.104, *Code of Iowa*	The board is composed of seven members appointed by the governor and confirmed by the senate. No more than four of the members can be from the same political party. Board members serve staggered four-year terms and must be reappointed and confirmed every four years.	The board meets monthly.	The board adopts and establishes policies for the operation and conduct of the Department of Corrections and the implementation of department programs. It also approves the locations for all state institutions which are penal, reformatory, or corrective.	The board recommends the names of individuals qualified for the position of director to the governor. In addition, the board can and has reported staff issues to the governor, who can and does impose sanctions.	The board makes recommendations regarding the department's budget and approves it prior to submission to the governor. The board also reviews fiscal reports provided to the board throughout the fiscal year and approves all department-initiated changes to the budget.	No.
Kentucky State Corrections Commission	Sections 196.700 to 196.735, *Kentucky Revised Statutes*	The commission is composed of 23 members, including the commissioner of the Department of Corrections (or his or her designee) and 3 at-large members appointed by the governor. Members serve three-year terms.	The commission is statutorily required to hold meetings at least once every four months. Special meetings may be held when needed as determined by the chairperson or if requested by five or more members of the commission.	The commission's duties include advising the governor and the commissioner concerning correctional policy and programs, including the need for, and the development of, new or specialized institutions, facilities, or programs as well as the need for, and the development of, useful research in penology, correctional treatment, criminal law, or relevant disciplines.	No.	The commission does not have budget authority over the Department of Corrections, but it does handle grant money given out by the department. These funds are awarded to judicial districts across the state, which create programs to try and reduce recidivism/costs by diverting individuals from the corrections system. The commission meets quarterly to audit the grants and see how they are being handled. The commission uses a portion of the funds to audit the grants.	The commission has no authority over the Department of Corrections. The commission does make recommendations regarding parole board vacancies, but the parole board is not under the control of the Department of Corrections.

State Correctional Oversight Entity	Authorization	Membership	Meeting Frequency	Powers and Duties	Personnel Decisions	Budget Authority	Ability to Make Changes to the Correctional Agency
New York State Commission of Correction	Article 3, *New York State Correction Law*	The commission is composed of three members appointed by the governor to five-year terms with the advice and consent of the senate. No member serves for more than 10 years.	The commission meets monthly.	The commission promulgates minimum standards for the management of correctional facilities; evaluates, investigates, and oversees correctional facilities; assists in developing new correctional facilities; and provides technical assistance.	No.	No.	The commission can make recommendations and require changes to ensure compliance with regulations. If the required changes are not followed, the commission has the authority to require compliance by getting a court order via the state supreme court. This usually only happens with police lockups or county jails, not state prisons.
Oklahoma Board of Corrections	Section 57-503, *Oklahoma Statutes*	Seven members appointed by the governor with the advice and consent of the senate. The board members serve six-year terms. One member is appointed from each congressional district and any remaining members are appointed from the state at large. Not more than four members of the board can be of the same political party.	The board meets monthly. Board committees, including the executive, audit/finance, public policy/affairs, population/private prisons, and female offender committees, usually meet once a month and report back to the board.	The board's powers and duties include establishing policies for the operation of the Department of Corrections, appointing and setting the salary of the director, and entering into contracts with private prison contractors. The board also has the power to require the director and any other personnel of the department to give bond for the faithful performance of their duties.	The board has hiring and firing authority over the director of the Department of Corrections. The director is the appointing authority for executive staff.	The board reviews and approves the department's proposed budget and emergency expenditures that exceed the director's authority.	The board is responsible for creating and approving the department's policies, which state the broad principles of the department. Procedures govern the daily operations of the agency and set forth the manner in which the policies are implemented. The director sets the procedures, and only the director may grant an exception to these procedures. While the board is not involved in the creation of procedures, they must be consistent with the policy statements of the board.
South Dakota Corrections Commission	Section 1-15-1.13, *South Dakota Codified Law*	The commission is composed of nine members, including three appointed by the governor; two senators, one from each political party, appointed by the respective political party caucus leader; two representatives, one from each political party, appointed by the respective political party caucus leader; and two members appointed by the chief justice of the supreme court.	The commission is statutorily required to meet twice a year and normally meets two or three times per year.	The commission assists the Department of Corrections in examining criminal justice issues and developing initiatives to address problems in corrections and the criminal justice system.	No.	The commission must approve all expenditures from the prison industries revolving fund, other than those for normal operating costs and replacement of existing necessary equipment, for the purposes of enhancement, development, or expansion of prison industries.	The board can make recommendations for policy changes. It also has an obligation to review statutes that affect the Department of Corrections.

State Correctional Oversight Entity	Authorization	Membership	Meeting Frequency	Powers and Duties	Personnel Decisions	Budget Authority	Ability to Make Changes to the Correctional Agency
Texas Board of Criminal Justice	Section 492.001, *Texas Government Code*	Nine members are appointed by the governor for staggered, six-year terms. The governor may not appoint more than two members who reside in an area encompassed by the same administrative judicial region.	The board is required by code to meet once every quarter. However, it generally meets every other month.	The board is responsible for hiring the executive director of the Department of Criminal Justice and setting rules and policies which guide the agency.	The board has hiring and firing authority for some department positions: the executive director, inspector general, the Prison Rape Elimination Act ombudsman, the head of the Internal Audit Division, the head of the Office of State Counsel for Offenders, and a few clerks. Other hiring and firing decisions are made by the department's executive director.	The board approves the budget and the legislative appropriations request.	The board approves amendments to operational policies proposed by the department on the use of force, offender access to courts, offender visitation, and other inmate issues.

Source: OPPAGA review of other states' correctional oversight entities.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

01-20-15
Meeting Date

Bill Number (if applicable)

Topic CORRECTIONAL OVERSIGHT ENTITIES

Amendment Barcode (if applicable)

Name MATTHEW MONCRIEF

Job Title SENIOR LEGISLATIVE ANALYST - OPPAGA

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TALLAHASSEE FL 32399
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Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing OPPAGA

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

Overview

CORRECTIONAL MEDICAL AUTHORITY

HISTORY OF THE CMA

1972

- A Federal lawsuit was filed by inmates in the Florida Department of Corrections which alleged inadequate medical care and overcrowding. This case is known as Costello

1986

- In 1986, after 14 years of unresolved litigation, the Florida legislature created the CMA

HISTORY OF THE CMA

1993

- After more than 21 years of litigation involving numerous studies, reports, agreements, and approximately 6 million dollars, Judge Susan Black signed an order closing the Costello lawsuit and returning control of Florida's prison health care to the State

1999

- Another Federal lawsuit, Osterback, was filed by Florida inmates which alleged among other things that placement of inmates in restricted housing units, known as “close management”, exacerbates symptoms of mental illness

2001

- A settlement agreement was reached by the Plaintiffs and the State of Florida in Osterback which in part required the CMA to conduct specific monitoring and reporting of close management within Florida’s prisons

HISTORY OF THE CMA

2004

- The CMA staff of 14 was reduced to six

2011

- CMA was not funded

2012

- CMA reinstated with 6 FTEs

CMA MISSION

- The mission of the CMA is to monitor and promote the delivery of cost-effective health care that meets accepted community standards to inmates in the

  Florida Department

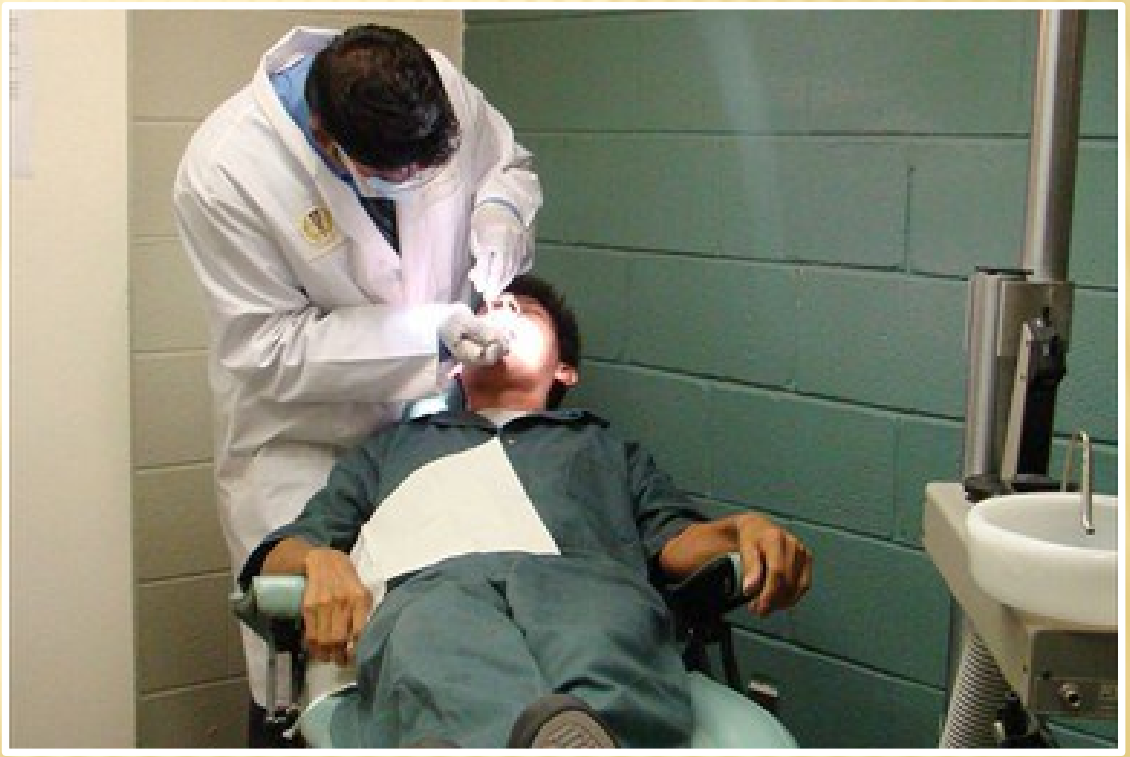
  of Corrections

CMA GOVERNING BOARD

- Seven member volunteer board appointed by the Governor and subject to confirmation by the Senate
  - Peter C. Debelius-Enemark, MD – Chair, Physician Representative
  - Katherine E. Langston, MD – Florida Medical Association Representative
  - Ryan D. Beaty – Florida Hospital Association Representative
  - Joyce A. Phelps, ARNP – Nursing Representative
  - Lee B. Chaykin – Healthcare Administration Representative
  - Harvey R. Novack, DDS – Dentistry Representative
  - Leigh-Ann Cuddy, MS – Mental Health Representative

SURVEY PROCESS

- F.S. 945.6031- Triennial Surveys
  - Physical health
  - Mental health
  - Dental



SURVEY PROCESS

- How do we survey?
  - **CMA analysts lead teams of contracted licensed health care professionals from the community**
  - Review inmate records
  - Interview staff
  - Interview inmates
  - Survey physical layout of the institution

SURVEY AND CORRECTIVE ACTION PLAN PROCESS

- Survey Report
  - Includes comprehensive list of deficiencies and corresponding suggested corrective actions
- Corrective Action Plan (CAP)
  - Institutional staff submit CAP outlining plans to correct each deficiency
  - CMA staff review monitoring of corrective actions and submit CAP assessment report
  - CMA continues to assess monitoring efforts until all deficiencies are corrected

QUALITY MANAGEMENT SUBCOMMITTEE OF THE BOARD

- F.S. 954.6032 Medical review committee that provides oversight for the Department's inmate health care quality management program. Committee consists of volunteer healthcare professionals and a board representative

QUALITY MANAGEMENT

- How do we provide oversight?
  - CMA staff attend the Department's Quality Management meetings
  - CMA Quality Management Committee assess the Contractor and Department's mortality review process
  - Report with recommendations for process improvement is sent to Director of Health Services

QUALITY MANAGEMENT

- Health Service Bulletin (HSB) Reviews
  - F.S. 945.6034 Department submits all health care standards to the CMA for review prior to adoption
  - CMA determines if HSBs conform to community standards of care

QUALITY MANAGEMENT

- Inmate letters
  - Receive letters from inmates
    or families regarding health care concerns
  - Refer to Office of Health Services,
    classification, institutional staff
    etc., or other appropriate entity

CMA ACTIVITIES

- 24 Institutions surveyed out of 56 since May 2013
- Over 30 Corrective Action Plan Assessments
- 3 Corrective Action Plan Trainings
- Monthly Board Meetings
- Quality Management Committee Meetings
- Annual Budget and Personnel Workgroup Meetings
- 64 Inmate Correspondence/31 responses
- 55 Health Service Bulletins reviewed
- CMA Annual Report and Report on Elderly Offenders

2013-14 ANNUAL REPORT SUMMARY

- Summary of CMA Activities
- Comprehensive list of findings from 13 surveys
- Physical and Mental Health Recommendations
- Summary of Corrective Action Plan Assessments
- Report on Elderly Offenders

CMA WEBSITE

- Published July 2014
- Complete list of current CMA Survey Reports and CAP Assessments
- Board Meeting Agendas and Minutes
- Annual Reports

- http://www.flgov.com/correctional-medical-authority-cma/

State of Florida

Correctional Medical Authority

2013-2014

Annual Report

And

Report on Elderly Offenders

State of Florida Correctional Medical Authority

Section 945.602, Florida Statutes, creates the Correctional Medical Authority (CMA).

The CMA's governing board is composed of the following seven people appointed by the Governor and subject to confirmation by the Senate:

Peter C. Debelius-Enemark, MD, Chair
Representative
Physician

Katherine E. Langston, MD
Representative
Florida Medical Association

Ryan D. Beaty
Representative
Florida Hospital Association

Joyce A. Phelps, ARNP
Representative
Nursing

Lee B. Chaykin
Representative
Healthcare Administration

Harvey R. Novack, DDS
Representative
Dentistry

Leigh-Ann Cuddy, MS
Representative
Mental Health

December 31, 2014

The Honorable Rick Scott
Governor of Florida

The Honorable Andy Gardiner, President
The Florida Senate

The Honorable Steve Crisafulli, Speaker
Florida House of Representatives

Dear Governor Scott, Mr. President, and Mr. Speaker:

In accordance with section 945.6031, Florida Statutes, I am pleased to submit the Correctional Medical Authority's (CMA) 2013-2014 Annual Report on the Florida Department of Corrections' health care delivery system.

This report summarizes our activities during Fiscal Year 2013-2014, which includes on-site physical and mental health surveys of 13 major correctional institutions, including two reception centers and four institutions with annexes or separate units. Additionally, 15 corrective action plan assessments were conducted based on findings from this and the previous year's surveys. It should be noted that the Fiscal Year 2012-2013 report assessed two facilities versus the 13 assessed this year due to the reestablishment of the CMA.

This report details the work of the CMA's governing board, staff, quality management committee, and budget and personnel workgroup towards the fulfillment of our statutory responsibility to assure that adequate standards of physical and mental health care are maintained in Florida's correctional institutions.

During Fiscal Year 2013-2014 the provision of health care services was transitioned from the Department of Corrections to a private contractor in the majority of the institutions in the state. Due to this transition, no definitive trends can be drawn from these survey results. Additionally, there have been changes to CMA methodology which create difficulty in comparing this report to CMA reports from previous fiscal years. The CMA strengthened its methodology of the survey process to include specific criteria to provide a comprehensive assessment of the provision of health care and to include updates from the Department's Health Services policies and procedures. These enhancements are reflected in this year's reporting.

Thank you for recognizing the important public health mission at the core of correctional health care and your continued support of the CMA. Please contact me if you have any questions or would like additional information about our work.

Sincerely,

Jane Holmes-Cain, LCSW
Executive Director

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BACKGROUND

CMA History

The Correctional Medical Authority (CMA) was created in July 1986, while the state's prison health care system was under the jurisdiction of the federal court from litigation that began in 1972. Costello v. Wainwright, 430 U.S. 57 (1977), was a class action suit brought by inmates alleging that their constitutional rights had been violated by inadequate medical care, insufficient staffing, overcrowding, and poor sanitation. The CMA was created as part of the settlement of that case and continues to serve as an independent monitoring body providing oversight of the systems in place to provide health care to the Department of Corrections (DOC) inmates.

In December 2001, DOC entered into a settlement agreement in a lawsuit (Osterback v. Crosby, 16 Fla. Weekly Fed. D 513 (N.D. Fla. 2003)) involving mentally ill inmates housed in close management (CM). The purpose of CM is to confine inmates separate from the general inmate population for reasons of security and for the order and effective management of the prison system. The Osterback agreement included a stipulation that the CMA monitor certain clinical, administrative, and security components of the program designed to ensure effective treatment of mental illness in the CM population. Facilities with CM are monitored as part of the regular CMA survey process.

The CMA carried out its mission to monitor and promote delivery of cost-effective health care that meets accepted community standards for Florida's inmates until losing its funding in the 2011 legislative session. However, the Governor vetoed a conforming bill which would have eliminated the CMA from statute and requested that funding be restored. The Legislature restored funding effective July 1, 2012.

Since that time, DOC has contracted with two private companies to provide comprehensive health care services for DOC inmates pursuant to DOC's expectations and standards. Specifically, in December 2012, Wexford Health Sources, Inc. (Wexford) began providing services for Florida inmates located at nine correctional institutions (CI) in South Florida: Hardee CI, DeSoto CI, Charlotte CI, Okeechobee CI, Martin CI, Everglades CI, Dade CI, Homestead CI, and South Florida Reception Center. In October 2013, Corizon, Inc. (Corizon) began providing services for Florida inmates located in Regions I and II, as well as the following

institutions in Region III: Avon Park CI, Hernando CI, Lake CI, Polk CI, Sumter CI, Zephyrhills CI, and Central Florida Reception Center. Due to the transition of the provision of health care from DOC to the private corporations, no definitive trends can be drawn from these survey results.

The CMA Board elected its Chair and appointed the Executive Director in April 2013. As of May 2013, the CMA resumed its statutory mandate to assure adequate standards of physical and mental health care for inmates are maintained at correctional institutions and to advise the Governor and Legislature on the status of DOC's health care delivery system now provided by the private contractors.

CMA Structure and Functions

The CMA is composed of a seven-member, volunteer board appointed by the Governor and confirmed by the Florida Senate for a term of four years. The board is comprised of health care professionals from various administrative and clinical disciplines who direct the activities of the CMA's staff. The CMA has a staff of six full-time employees and utilizes independent contractors to complete triennial health care surveys at each institution. Survey reports are followed by monitoring of corrective action plans until such time as the institutions are in compliance with accepted community standards of care. The CMA is an independent reporting agency administratively housed within the Executive Office of the Governor and is charged with the responsibility of overseeing DOC's health care delivery system. The CMA's statutory purpose is to assist the delivery of health care services for inmates by advising the Secretary of Corrections of the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care.

By ensuring that the quality of inmate care remains in compliance with accepted standards, the CMA provides an important risk management function for the State of Florida's correctional health care system, as the right of inmates to access adequate health care has been constitutionally guaranteed and upheld by the courts (Estelle v. Gamble 429 U.S. 97 (1976)). It is important to remember the CMA and all functions set forth by the Legislature resulted from federal court findings that Florida's correctional system provided inadequate health care and an oversight agency with board review powers was needed.

It is well documented that inmates are disproportionately more likely to suffer from a variety of chronic communicable diseases, mental health problems, and substance abuse issues than persons in the community. More than 18 % of hepatitis C virus carriers in the country and one-third of those with active tuberculosis pass through the jail or prison system.[1] Inmates are affected by HIV/AIDS in greater numbers.[2] Inmates are also disproportionately affected by other chronic health conditions, including diseases of the cardiovascular and respiratory systems, as well as certain types of cancers.[3]

Many inmates come into prison with poor health status due to lack of preventive medical and dental care, untreated chronic disease, mental illness, years of substance dependence (e.g., alcohol, tobacco, illicit drugs), and the effects of previous incarcerations. The generally poorer health status of inmates and the aging population combined with the increasing cost of health care has resulted in medical care being a primary contributor to steadily increasing state budgets.[4]

The CMA's specific duties and authority are detailed in sections 945.601–945.6035, Florida Statutes, and include:

- Reviewing and advising the Secretary of Corrections on DOC's health services plan, including standards of care, quality management programs, cost containment measures, continuing education of health care personnel, budget and contract recommendations, and projected medical needs of inmates.

- Reporting to the Governor and Legislature on the status of DOC's health care delivery system, including cost containment measures and performance and financial audits.

[1.] National commission on correctional health care (2004). *The health status of soon-to-be released inmates: A report to congress, Volume 1.* September 2001. (No. 189735). Chicago, IL. Author.

[2.] Department of Justice (2010, September) *Office of Justice Programs, Bureau of Justice Statistics Bulletin,* Washington, D.C. U.S. Retrieved November 11, 2013 from http://www.bjs.gov/index.cfm?ty+pbdetail&iid=4452.

[3.] Binswanger, IA., Krueger, P.M., Steiner, J.F. (2009) *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population.* Journal of Epidemiology and Community Health,63: 912-919.

[4.] Aging Inmate Committee, American Correctional Association, *Aging Inmates: Correctional Issues and Initiatives,* Corrections Today, August/September 2012, 84-87.

- Conducting surveys of the physical and mental health services at each correctional institution every three years and reporting findings to the Secretary of Corrections.
- Reporting serious or life-threatening deficiencies to the Secretary of Corrections for immediate action.
- Monitoring corrective actions taken to address survey findings.
- Providing oversight for DOC's quality management program to ensure coordination with the CMA.
- Reviewing amendments to the health care delivery system submitted by DOC prior to implementation.

As part of its reporting duties, each year the CMA submits two reports to the Governor and Legislature. The first is the Annual Report, which summarizes the CMA's activities for the fiscal year and reports on the status of DOC's health care delivery system. The second is the Report on Elderly Offenders, which reports on the status and treatment of elderly offenders in the state-administered and private state correctional systems and DOC's geriatric facilities and dorms. The next section of this document contains the Annual Report for Fiscal Year 2013-14 (FY 2013-14), and the final section of this document contains the 2013-14 Report on Elderly Offenders.

2013-14 ANNUAL REPORT

This Annual Report describes the activities of the CMA during FY 2013-14. Specifically, it addresses Board and staff activities, the findings of 13 on-site institutional surveys, the results of 15 corrective action plan assessments, and the CMA's medical review, quality management, and budget review committee activities.

Board Activities

The CMA Board held six public meetings during FY 2013-14 and provided valuable support and guidance to staff. The Board recommended that survey reports include enhanced discussions on the physical, mental, and dental health findings as well as data on the staffing patterns and vacancies at each institution.

The Board supported the Executive Director's cost-saving measures, including reducing travel costs by conducting entrance and exit interviews via conference call when feasible and more efficient scheduling of corrective action plan (CAP) assessments to coordinate with survey travel.

In October 2013, the final board seat for mental health representation was filled and a contract for legal services was executed. The Board approved the FY 2012-13 Annual Report and FY 2014-15 Budget Letter for submission to the Governor and Legislature in December and January, respectively. In June 2014, the Board chose to transition to a monthly meeting schedule in FY 2014-15 to ensure the members remain informed of survey results and ongoing corrective action plan updates in a timely manner.

Staff Activities

This year, in addition to conducting surveys and monitoring corrective action plans, staff furthered the CMA's purpose of assisting in the delivery of health care services for inmates by participating in continuing education and training, conducting policy review, directing inmate correspondence, and publishing a website on which the CMA's reports are easily accessible to the public.

Education and Training

CMA licensed staff participated in continuing education activities to ensure compliance with licensure requirements. Additionally, staff attended a conference focusing on awareness and education about trauma-informed care practices within agencies, including corrections. Staff also attended the Corrections Infections Workgroup where members share information and provide program education to improve infectious disease screening for inmates throughout Florida. In January 2014, the CMA Executive Director conducted a training seminar for Wexford and Corizon leadership. This training was designed to assist in the creation and implementation of successful corrective action plans within the institutions.

Policy Review

Pursuant to section 945.6034, Florida Statutes, DOC submits all health care standards to the CMA for review prior to adoption. All revisions to the health care delivery system's health services bulletins (HSB), policies, procedures, and forms are reviewed by CMA analysts. In FY 2013-14, CMA analysts reviewed 28 physical health and 7 mental health HSBs and provided recommendations as needed to ensure DOC's health service plan continues to meet acceptable standards of community care for inmates. These reviews resulted in a critical update to the guidelines for administering pneumococcal vaccines and facilitation of proper documentation of all baseline and ongoing health information in health records.

Inmate Correspondence

As part of its mission to ensure adequate standards of physical and mental health care are maintained at all institutions, CMA staff respond to inmate concerns received via written correspondence and telephone contact. During FY 2013-14, the CMA responded to 24 communications concerning 16 inmates at 11 different correctional institutions. The CMA is not authorized to direct staff in DOC institutions or require specific actions be taken and therefore forwards inmate concerns to the Office of Health Services (OHS) for investigation and response. At the close of this fiscal year, 14 of these inmates had received responses to their concerns. Health care issues identified in inmate's letters are subsequently reviewed during on-site surveys. The CMA collaborates with OHS to prevent systemic deficiencies in health care from occurring. Monitoring inmate correspondence is another important risk management function of the CMA.

CMA Website

In FY 2013-14, the CMA published its website at http://www.flgov.com/correctional-medical-authority-cma, which includes a summary of the services provided, a complete listing of published reports, and contact information. There has been a steady increase in communications from inmates and their families since the site was published and it is expected this trend will continue as the public is made aware of the role the CMA performs for the State of Florida's correctional health care system.

Surveys

The CMA recruits and trains licensed health care practitioners, including physicians, psychiatrists, psychologists, mental health professionals, dentists, physician assistants, nurse practitioners, and registered nurses to survey health care services in prison facilities. In FY 2013-14, the CMA utilized 62 licensed health care professionals as independent contractors throughout Florida.

Staff schedule surveys at institutions from all three regions in the state to ensure each institution will be surveyed every three years as statutorily mandated and to provide the most cost-effective allocation of CMA resources.

In FY 2013-14, the CMA completed 13 surveys, which included two reception centers and four institutions with an annex or separate unit and two private institutions managed by the Department of Management Services. The following table shows the correctional institutions (CI) and facilities (CF) surveyed by region.

Region I	Region II	Region III
Jefferson (JEFCI) Santa Rosa (SARCI) Santa Rosa Annex (SARCI-ANNEX) Taylor (TAYCI) Taylor Annex (TAYCI-ANNEX) Gadsden (GADCF)	Cross City (CROCI) Suwannee (SUWCI) Suwannee Annex (SUWCI-ANNEX) Florida State Prison (FSP) Florida State Prison – West (FSP-WEST)	South Florida Reception (SFRC) South Florida Reception – South (SFRC-SOUTH) Homestead (HOMCI) Martin (MATCI) Central Florida Reception (CFRC) Central Florida Reception – East (CFRC-EAST) Hernando (HERCI) South Bay (SBCF)

The survey process begins with a pre-survey questionnaire completed by institutional staff prior to the survey for CMA to prepare team schedules and record selections. CMA analysts utilize the pre-survey questionnaire along with requested logs and Offender Based Information System (OBIS) reports to identify inmates eligible to receive or currently receiving specific physical and/or mental health services at the institution. From this information, cases are randomly selected and the inmate's medical record requested for on-site review. Record reviews consist of a clinical analysis of the physical, dental, and mental health care provided based on DOC's and community established standards of care published in collaboration with the CMA's oversight.

CMA employs a selection process based on the size of the clinic with an 80 % confidence level. There must be a finding of deficiency with the standard in at least 20 % of records reviewed in the selected sample to constitute a finding in the survey report. Administrative issues such as the existence and application of written policies and procedures, staff training, and confinement practices are also reviewed.

CMA surveyors also conduct a physical inspection of the facilities to confirm that medical, dormitory, and confinement areas meet acceptable standards of sanitation and that all needed equipment and supplies are adequately maintained and available.

Conclusions drawn by members of the survey team are based on the following methods of evidence collection:

- Physical evidence – direct observation (tours and observation of evaluation/treatment encounters);
- Testimonial evidence – obtained from staff and inmate interviews and substantiated through investigation;
- Documentary evidence – obtained through the review of specific materials, including assessments, service/treatment plans, schedules, logs, administrative reports, records, physician's orders, and training records;
- Analytical evidence – developed by comparative and deductive analysis from several pieces of gathered evidence.

Surveyors use uniform tools based on DOC's HSBs, policies, procedures, and manuals, which dictate the requirements for the provision of adequate health care for inmates, to complete record reviews. In FY 2013-14, CMA staff and surveyors examined over 4,500 inmate physical and mental health records, finding a total of 835 health care deficiencies as reported to the Secretary of Corrections. Of the 13 institutions surveyed it should be noted that reception services are provided at 2 sites and inpatient mental health care at 3 sites. All findings represent a potential for error in patient care and a failure to meet adequate standards of care. The following pages contain a comprehensive breakdown of the survey findings in FY 2013-14. Complete survey reports for each institution may be obtained from the CMA website at: http://www.flgov.com/correctional-medical-authority-cma/.

Physical Health Findings

Chronic Illness Clinics
The diagnoses were not documented on the problem list. **(JEFCI, CROCI, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, SBCF)**
The baseline history, physical exam, and/or laboratory work were incomplete or missing. **(JEFCI, CROCI, SUWCI-ANNEX, SARCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI, FSP, FSP-WEST, GADCF, SBCF)**
There was no initial and/or ongoing education information documented. **(JEFCI, CROCI, SARCI-ANNEX, SFRC, CFRC-EAST, GADCF)**
The physical examinations were not sufficient to assess the patient's condition. **(CROCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, GADCF)**
There was no evaluation of the control of the disease and/or patient status. **(JEFCI, CROCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI**)
The documentation was not legible, dated, timed, signed, and/or stamped. **(JEFCI, SARCI-ANNEX, SFRC-SOUTH, TAYCI, GADCF)**
Cardiovascular Clinic
Completed labs were not available to the clinician prior to the clinic visit and/or abnormalities were not addressed in a timely manner. **(GADCF)**
Inmates with atherosclerotic cardiovascular disease were not prescribed low dose aspirin. **(FSP)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, CFRC-EAST, FSP, FSP-WEST)**
Endocrine Clinic
The annual laboratory work was incomplete or missing. **(FSP-WEST, GADCF)**
There were no annual fundoscopic exams. **(SUWCI-ANNEX, MATCI, TAYCI, TAYCI-ANNEX, HERCI, FSP, FSP-WEST)**
Inmates with vascular disease were not prescribed aspirin. **(SFRC, HERCI)**
There were no evidence of ACE or ARB therapies. **(HOMCI, MATCI, HERCI)**
Inmates were not seen at the required intervals. **(SUWCI-ANNEX)**
Inmates with HgbA1c levels over 8.0 were not seen every 4 months. **(JEFCI, SARCI-ANNEX)**
There was no evidence of efforts to reduce HgbA1c levels over 7.0. **(JEFCI)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SUWCI-ANNEX, HOMCI, TAYCI, TAYCI-ANNEX, SFRC, HERCI, FSP, FSP-WEST, GADCF, SBFC)**

Gastrointestinal Clinic
The annual laboratory work was incomplete and/or missing. **(CFRC-EAST, GADCF)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, MARTCI, TAYCI, TAYCI-ANNEX)**
Inmates with hepatitis C and no history of A&B infection were not given hepatitis A&B vaccines. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, FSP-WEST, GADCF, SBCF)**
There was no referral to a specialist when indicated. **(GADCF)**
Immunity Clinic
Inmates were not seen at the required intervals. **(SFRC)**
There was no evidence of hepatitis B vaccines or refusals. **(JEFCI, SUWCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, MATCI, TAYCI, TAYCI-ANNEX, CFRC, HERCI, GADCF)**
Serological testing for hepatitis B was incomplete or missing. **(SFRC)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, TAYCI, TAYCI-ANNEX, FSP-WEST, GADCF)**
HIV medications were out of stock. **(TAYCI)**
Miscellaneous Clinic
Laboratory studies were not completed prior to the clinic visit. **(TAYCI-ANNEX)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SUWCI, TAYCI, TAYCI-ANNEX, CFRC, HERCI, FSP-WEST)**
There were no referrals to a specialist when indicated. **(MATCI, TAYCI-ANNEX)**
Neurology Clinic
The annual laboratory work was incomplete or missing. **(GADCF)**
Seizures were not classified or were classified incorrectly. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, TAYCI-ANNEX, CFRC, HERCI, FSP-WEST)**
There were no discussions of medication tapering after two years without seizures. **(JEFCI, TAYCI-ANNEX)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SARCI-ANNEX, SFRC, TAYCI, HERCI, GADCF)**
There were no referrals to a specialist when indicated. **(MATCI, HERCI)**
Oncology Clinic
The baseline marker studies were not completed. **(TAYCI, CFRC-EAST)**
There was no evidence labs were reviewed and addressed timely. **(SFRC)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SFRC, SFRC-SOUTH, HOMCI, TAYCI-ANNEX, HERCI, FSP, FSP-WEST)**
There was no referral to a specialist when indicated. **(SFRC-SOUTH)**

Respiratory Clinic
The severity of reactive airway diseases were not documented. **(JEFCI, TAYCI-ANNEX, CFRC-EAST, FSP-WEST)**
Patients with moderate to severe reactive airway disease were not started on anti-inflammatory medication. **(SFRC)**
Rescue inhaler use greater than twice weekly was not addressed. **(JEFCI)**
Appropriate medications were not prescribed and/or reevaluated at each clinic visit. **(JEFCI)**
Inmates were not seen at the required intervals. **(SFRC)**
There was no evidence of peak flow readings at each clinic visit. **(TAYCI, FSP-WEST)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI, FSP, FSP-WEST)**
Tuberculosis Clinic
There were no evidence of monthly nursing follow-ups. **(JEFCI, MATCI)**
Tuberculosis medications were not discontinued for elevated AST/ALT and/or adverse reactions. **(MATCI, SBCF)**
The correct number of INH doses were not given. **(JEFCI)**
There were no referrals for the final clinician visit. **(JEFCI, MATCI)**
The laboratory work was not available or reviewed/addressed timely. **(MATCI)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SARCI-ANNEX, SFRC, MATCI, CFRC-EAST, FSP, FSP-WEST)**
Emergency Care
Applicable education was not provided. **(JEFCI)**
Complete vital signs were not documented. **(MATCI, HERCI)**
Follow-up visits were not initiated and/or completed timely. **(JEFCI, TAYCI-ANNEX)**
The follow-up assessment did not adequately address the presenting complaint. **(CFRC)**
Sick Call
The nursing assessment was incomplete. **(MATCI)**
Applicable education was not provided. **(JEFCI, SUWCI-ANNEX, SARCI, TAYCI)**
Complete vital signs were not documented. **(TAYCI)**
Follow-up visits were not initiated and/or completed timely. **(TAYCI, TAYCI-ANNEX)**
The follow-up assessment did not adequately address the presenting complaint. **(JEFCI)**
There was no evidence the clinician's orders from the follow-up visit were completed. **(TAYCI)**
The follow-up documentation was not completed, legible, or timely. **(TAYCI)**

Consultations
The diagnoses were not documented on the problem lists. **(JEFCI,CROCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, CFRC, HERCI, FSP, FSP-WEST, GADCF)**
There was no evidence the consultation requests were approved with the signatures of the Chief Health Officer or designee. **(HOMCI, TAYCI)**
The clinical information was insufficient to obtain the consultation services. **(TAYCI-ANNEX)**
Consultations or follow-ups were not initiated and/or completed timely. **(TAYCI, TAYCI-ANNEX)**
The consult reports were not signed, stamped, and/or dated. **(SFRC, SFRC-SOUTH)**
The consultant's recommendations were not incorporated into the treatment plan. **(SUWCI-ANNEX, SFRC, HERCI)**
The consultation logs were incomplete or inaccurate. **(JEFCI, HOMCI, MATCI, TAYCI-ANNEX)**
The clinicians did not document a new plan of care following denial by Utilization Management. **(JEFCI, SFRC-SOUTH, MATCI, TAYCI-ANNEX, HERCI, GADCF)**
Infirmary
The admission orders were incomplete or missing. **(JEFCI, SFRC, GADCF)**
The nursing assessments were not completed within two hours of admission. **(JEFCI, CFRC)**
There was no evidence medications were administered according to orders. **(TAYCI)**
Evidence of daily rounds for acute patients or weekly rounds for chronic patients were missing. **(JEFCI, SFRC)**
Identified nursing problems were not addressed. **(JEFCI, SFRC)**
There were no separate and complete inpatient files. **(JEFCI, SFRC, MATCI, TAYCI, GADCF)**
Documentation for discharges were incomplete or missing. **(JEFCI, SFRC, TAYCI, CFRC, FSP-WEST, GADCF)**
Dental Care
The dark room did not have a safe light for developing X-rays. **(JEFCI)**
Guidelines were not properly followed when taking radiographs. **(HERCI)**
Prosthetic devices were not appropriately disinfected between patients. **(CFRC)**
Dental licenses were not posted. **(HERCI)**
The dental stock medications log was not found in the dental clinic. **(HERCI)**
Preventive dentistry/oral hygiene posters and/or American Heart Association prophylactic regimens were not posted in the dental unit. **(CFRC, HERCI)**
Adequate supplies of personal protective equipment were not available for staff. **(CFRC-EAST)**
Operatories were not in proper working order. **(CFRC-EAST)**
Emergency eyewash station were improperly located. **(HERCI)**

Dental Care
Dental clinic faucets were not touch operated. **(HERCI)**
Dental health questionnaires were not reviewed. **(SARCI-ANNEX)**
The allergy boxes were not completed on the dental record. **(FSP)**
There was no evidence of accurate diagnoses or treatment plans. **(SFRC-SOUTH)**
Intra-System Transfers
Complete vital signs were not documented. **(CFRC)**
The clinician did not review the health record within seven days. **(CROCI, CFRC, HERCI, FSP)**
Arrival/Transfer summaries were incomplete. **(TAYCI, CROCI, CFRC, HERCI, SBCF)**
Pending consultations were not added to the consultation log. **(SFRC)**
Clinic appointments did not take place as scheduled. **(SFRC)**
Medication Administration
Medication orders were not signed, dated, and/or timed. **(SUWCI, SARCI-ANNEX, MATCI, GADCF)**
There was no documentation of the administration route or strength of medication. **(CROCI, SARCI, HERCI, FSP)**
There was no evidence that counseling was provided after medication refusals. **(MATCI)**
Medication orders were not transcribed within the necessary time frame. **(CROCI, CFRC)**
The Medication Administration Records (MARs) did not accurately reflect allergies. **(HOMCI)**
The MARs were not completed, signed and/or initialed. **(MATCI, TAYCI)**
The MAR reviews indicated lapses in medication administration. **(MATCI)**
Periodic Screening
The periodic screening encounter were not documented. **(SARCI-ANNEX)**
Periodic screening encounters were not conducted within one month of the due date. **(SFRC, TAYCI, CFRC)**
There was no evidence all required diagnostic tests were completed timely. **(SUWCI, SFRC, TAYCI, CFRC, GADCF)**
There was no evidence the screenings included all necessary components. **(SUWCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, TAYCI, CFRC, GADCF)**
There was no evidence the inmates were provided with lab results at the screenings. **(SUWCI-ANNEX, TAYCI)**
There was no evidence health education was provided or included all required components. **(SUWCI-ANNEX, TAYCI)**
There was no evidence of referral to the clinician when indicated. **(MATCI)**
The mammography study was not found in the chart. **(HERCI – 2 applicable sites)**

Pill Line
Administering personnel did not wash hands or put on gloves. **(SUWCI, SUWCI-ANNEX, HERCI)**
Oral cavity checks were not conducted by health care personnel. **(SUWCI-ANNEX, MATCI, FSP-WEST)**
Staff did not verify the medication label matched the MAR. **(HERCI)**
The pill room was in disrepair. **(SFRC)**
Pharmacy Services
Controlled substances inventory and invoices were not available. **(SARCI-ANNEX)**
There was no evidence the consulting pharmacist provided annual in-service training for medical staff. **(SARCI, SARCI-ANNEX)**
The consulting pharmacist did not conduct required monthly reviews of MARs. **(CFRC)**
Blood glucose test strips were not dated for expiration and/or were outdated. **(SUWCI, SUWCI-ANNEX)**
There was inadequate space and storage for medications in the pharmacy areas and/or discarded stock medications were not witnessed properly. **(HOMCI, TAYCI, FSP)**
Reception Process (2 Applicable Facilities)
The required tests were not completed within seven days. **(CFRC)**
Laboratory results were not conveyed to the inmate and/or appropriately addressed. **(CFRC)**
There were no problem lists in the medical records. **(CFRC)**
There was no evidence of referral to the clinician when indicated. **(CFRC)**
Institutional Tour
All infirmary beds were not within site or sound of the nurse's station. **(SUWCI, MATCI)**
Medical areas were unorganized, medications improperly stored, and no sharps/biohazard containers available. **(MATCI)**
Personal protective equipment for universal precautions was not available in all required areas. **(JEFCI, MATCI)**
Negative air pressure in medical isolation rooms was inadequate and/or not checked daily when in use. **(SFRC, MATCI, SARCI-ANNEX, TAYCI)**
The blood glucose meters were not in the emergency kit, calibrated, logged, and/or tested timely. **(SARCI-ANNEX, CFRC-EAST, TAYCI-ANNEX)**
There were no hand or eye washing stations and/or products in the appropriate areas. **(SFRC, MATCI, SARCI, SARCI-ANNEX)**
Over-the-counter medications were not current or available in all areas. **(SFRC-SOUTH, TAYCI-ANNEX, FSP)**
Medical equipment was not in proper working condition. **(FSP, FSP-WEST)**
The specimen refrigerator in lab room did not have a biohazard label. **(SARCI-ANNEX)**
There were unclean living conditions and inoperative fixtures noted in dormitory areas. **(SARCI, MATCI, CFRC)**
There was no documentation that first aid kits were inspected monthly. **(SFRC-SOUTH)**

Mental Health Findings

Self-harm Observation Status (SHOS)
Admission orders were not signed/countersigned and/or dated/timed. **(JEFCI, CROCI, MATCI, CFRC, FSP, GADCF)**
Emergency evaluations were not completed prior to SHOS admissions. **(SUWCI, SARCI-ANNEX, TAYCI, CROCI)**
Admission forms were not completed within 2 hours. **(SUWCI, CFRC)**
Inmates were not evaluated on the 4th day to determine if transfer to a Crisis Stabilization Unit (CSU) was needed. **(MATCI, SARCI, TAYCI)**
Clinician's orders did not specify observations every 15 minutes. **(SARCI-ANNEX, CFRC)**
There was no documentation inmates were observed at the frequency ordered by the clinician. **(JEFCI, SUWCI, SARCI-ANNEX, MATCI, FSP)**
Daily nursing evaluations were not completed once per shift. **(JEFCI, MATCI)**
Daily rounds by the clinician were not documented. **(JEFCI, CROCI, SUWCI, SARCI, TAYCI)**
There was no evidence of face-to-face evaluations by the clinician prior to discharge. **(SUWCI, SARCI, TAYCI, GADCF)**
There was no evidence of daily counseling by mental health staff. **(SARCI)**
There was no evidence inmates were seen by mental health staff for post-discharge follow-ups. **(SUWCI, TAYCI, GADCF)**
Entries were not dated, timed, signed, and/or stamped. **(CROCI)**
Mental Health Restraints
Precipitating behavioral signs indicating the need for psychiatric restraints were not documented. **(SFRC)**
Less restrictive means of behavioral control were not documented. **(SARCI-ANNEX, SFRC)**
Telephone orders for restraints were not signed by the clinician. **(MATCI)**
Physician orders did not contain the maximum duration of restraint. **(SFRC)**
There was no documentation inmates were offered fluids or bedpans/urinals every 2 hours. **(SARCI-ANNEX, SFRC, MATCI)**
There was no documentation of inmates' behavior every 15 minutes. **(MATCI)**
There was no documentation inmates' respiration or circulation were checked every 15 minutes. **(SARCI-ANNEX, MATCI)**
There was no documentation inmates' vital signs were taken when released. **(SARCI-ANNEX)**
There was no documentation inmates' limbs were exercised every 2 hours. **(SARCI-ANNEX)**
Restraints were not removed after 30 minutes of calm behavior. **(SFRC)**

Use of Force
Written referrals to mental health were not completed or present in the record. **(JEFCI, MATCI, CFRC, GADCF)**
There was no indication inmates were interviewed by the next working day to determine the level of mental health care needed. **(JEFCI, SUWCI, SARCI-ANNEX, CFRC, GADCF)**
Post use of force physical exams were not completed. **(GADCF)**
Psychological Emergency
Entries were not dated and/or timed. **(SUWCI-ANNEX)**
Responses to mental health emergencies were not documented. **(TAYCI)**
Emergencies were not responded to within 1 hour. **(HOMCI, TAYCI, GADCF)**
Dispositions were not appropriate based on documentation. **(TAYCI-ANNEX)**
There was no appropriate follow-up in response to emergencies. **(TAYCI-ANNEX)**
Inmate Request
Copies of inmate requests were not found in the records. **(JEFCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST)**
Entries were not signed, dated, and/or stamped. **(SUWCI-ANNEX)**
Inmate requests were not responded to within 10 days. **(CFRC)**
Interviews/referrals indicated in requests did not occur as indicated. **(SBCF)**
Special Housing
Mental status exams (MSEs) were not completed within the required timeframe. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX)**
Follow-up MSEs were not completed within the required timeframe. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, TAYCI, TAYCI-ANNEX)**
Special housing health appraisals were incomplete or missing. **(MATCI, TAYCI, CFRC)**
Outpatient treatment was not continued as indicated on Individualized Service Plans (ISPs). **(JEFCI)**
There was no documentation that problems with adjustment were responded to appropriately by mental health staff. **(SUWCI-ANNEX)**
Psychotropic medications were not continued. **(CFRC, GADCF)**
Inpatient Psychotropic Medications (3 Applicable Sites)
Psychiatric evaluations did not address all issues. **(SUWCI)**
Initial lab tests were not completed as required. **(SUWCI, SFRC)**
Clinicians' admission notes were not completed within 24 hours. **(SARCI-ANNEX)**
Clinicians' orders were not dated and/or timed. **(SUWCI, SARCI-ANNEX)**
Medications prescribed were not appropriate for symptoms and diagnosis. **(SFRC)**
Signed informed consents for each class of medication were not present. **(SUWCI, SFRC)**
Follow-up lab tests were not completed as required. **(SUWCI, SARCI-ANNEX, SFRC)**
Rationale for Emergency Treatment Orders (ETOs) were not documented. **(SUWCI)**
ETOs were not countersigned, dated, and/or timed. **(SUWCI)**

Inpatient Mental Health Services (3 Applicable Sites)
There was no documentation that inmates were oriented to the unit within 4 hours of admission. **(SUWCI)**
Vital signs were not documented daily for the first 5 days for new admissions. **(SFRC)**
Inmates were not offered the required hours of planned structured therapeutic services. **(SUWCI, SARCI-ANNEX, SFRC)**
Vital signs were not documented at required intervals. **(SFRC)**
Weekly weights were not documented. **(SFRC)**
Outpatient Psychotropic Medication
There was no evidence of appropriate initial laboratory work. **(JEFCI, SUWCI-ANNEX, SARCI, CFRC)**
Psychiatric evaluations were not completed prior to prescribing psychotropic medications. **(MATCI, CFRC, HERCI, FSP)**
Abnormal lab tests were not followed up as required. **(SUWCI, SUWCI-ANNEX, SFRC, CFRC, HERCI, FSP, GADCF)**
Clinicians' orders were not dated, timed, and/or signed. **(JEFCI, MATCI)**
Approved drug exception requests were not present when medications were prescribed for non-approved use. **(SFRC)**
Inmates did not receive medications as prescribed nor were refusals found in medical records. **(JEFCI, SUWCI-ANNEX, SFRC, CFRC)**
Informed consents were not present or did not reflect relevant information to the prescribed medications. **(SUWCI-ANNEX, SFRC, MATCI, CFRC, HERCI)**
Signed refusals were not present in the records after three consecutive or five in one month medication refusals. **(JEFCI)**
There was no evidence nursing staff met with inmates refusing medication for two consecutive days. **(SARCI)**
Follow-up laboratory tests were not completed as required. **(JEFCI, SUWCI, SUWCI-ANNEX, SFRC, HERCI, GADCF)**
Abnormal Involuntary Movement Scales (AIMS) were not administered when required. **(SUWCI-ANNEX, SARCI, CFRC, HERCI, FSP)**
Follow-up sessions were not conducted at appropriate intervals. **(JEFCI, CFRC, HERCI)**
Outpatient Mental Health Services
There was no indication instructions for accessing mental health care were provided. **(CROCI, SUWCI-ANNEX, SFRC)**
Arrival/Transfer Summaries lacked required information or were not completed timely. **(HOMCI, FSP, CFRC-EAST, SFRC)**
Consents for treatment were not signed prior to initiation or renewed annually. **(TAYCI, TAYCI-ANNEX)**

Outpatient Mental Health Services
Case managers were not assigned within three working days. **(JEFCI, SUWCI-ANNEX, HERCI, SBCF)**
Current medications prescribed from sending institutions were not continued prior to the initial appointment with psychiatry. **(JEFCI, SUWCI, HERCI, SBCF)**
Inmates were not seen by psychiatry prior to the expiration of current medication. **(JEFCI)**
Inmate interviews and/or mental health screening evaluations were not completed within 14 days of arrival. **(JEFCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, HERCI)**
Sex offender screenings were not present in records. **(SARCI-ANNEX, CFRC-EAST)**
Consents and/or refusals to sex offender treatment were not present in records. **(JEFCI)**
Biopsychosocial assessments (BPSAs) were not approved by multidisciplinary treatment teams (MDST) within 30 days. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, GADCF)**
ISPs were not completed within 14 days. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, HERCI)**
ISPs were not signed by the MDST and/or inmates or there were no documented refusals. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, FSP-WEST)**
ISPs lacked pertinent information and were not individualized. **(TAYCI, TAYCI-ANNEX, GADCF)**
ISPs were not reviewed or revised at 180 days. **(JEFCI, SUWCI-ANNEX, SARCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST)**
Mental health problems were not documented on problem lists. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF, CFRC, CFRC-EAST)**
There was no documentation inmates received services listed on ISPs. **(JEFCI, SARCI)**
Counseling was not provided every 30 days for inmates diagnosed with psychotic disorders. **(JEFCI, GADCF)**
Counseling was not provided every 90 days for inmates without psychotic disorders. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF)**
Case management was not conducted every 90 days. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF)**
There were insufficient details in progress notes to follow the course of treatment. **(TAYCI, TAYCI-ANNEX)**
Frequency of clinical contacts were not sufficient. **(JEFCI, TAYCI, TAYCI-ANNEX)**

Aftercare Planning
Aftercare plans were not addressed in ISPs. **(SUWCI-ANNEX, SARCI-ANNEX, HERCI)**
Consent and authorization forms were not signed by inmates. **(SARCI-ANNEX)**
Summaries of care were not completed within 30 days of End of Sentence (EOS). **(SUWCI-ANNEX, SARCI-ANNEX, SFRC, HERCI, GADCF)**
Assistance with Social Security benefits was not provided within 90 days of EOS. **(SARCI-ANNEX, HERCI, SBCF)**
Reception Process (2 Applicable Sites)
Psychotropic medications were not continued from county jail. **(SFRC)**
Psychiatric evaluations were not completed within 10 days as required. **(CFRC)**
There were no signed releases or refusals for treatment records for inmates in reception over 60 days. **(CFRC)**
Administrative Issues
Therapeutic groups were not conducted. **(JEFCI)**
Weekly clinical supervision for psychological specialist were not consistently conducted. **(JEFCI, TAYCI, TAYCI-ANNEX)**
There were safety concerns including paint and mesh peeling from Isolation Management Rooms. **(SFRC, FSP, FSP-WEST, GADCF)**
Inmates on close management were not provided the opportunity to sign a refusal for group activities. **(FSP)**
Inmate request logs were not completed. **(TAYCI, TAYCI-ANNEX)**
Inmates in special housing were not offered opportunities to speak out of cell to mental health staff during therapeutic contacts. **(GADCF)**
Psychological emergency logs were not completed. **(TAYCI, TAYCI-ANNEX)**
MDST meetings were not held regularly. **(TAYCI, TAYCI-ANNEX)**
There were no protective helmets present. **(CFRC)**

Recommendations for FY 2013-14

Based on these survey findings the CMA makes the following recommendations:

Physical Health

- Review policies regarding the documentation of baseline health information (e.g., physical examinations, laboratory results, and assessment information) with institutional staff to ensure proper documentation requirements are met;
- Determine a method to guarantee hepatitis, pneumococcal, and influenza vaccinations are completed according to policy and in a timely manner;
- Determine a method to guarantee that problem lists are current and complete to provide an ongoing guide for reviewing the health status of patients and planning appropriate care;
- Consider developing guidelines for physicians and clinical associates that address requirements of appropriate physical examinations, treatment provision, writing medication and treatment orders, and overall clinical management;
- Provide additional training for physicians and clinical associates regarding timely follow-up of consultations and documentation of a new plan of care following denial of consultation by Utilization Management;
- Determine a method to ensure that procedures to access medical, dental, and mental health care services remain posted in dormitory areas.

Mental Health

- Ensure the required hours of planned structured therapeutic services are provided and documented;
- Create and maintain a system to track use of force episodes indicating inmates in need of mental health follow-up are seen as required;

- Provide additional training for clinicians in the area of required psychiatric laboratory tests (i.e., initial, follow-up, and abnormal follow-up);
- Ensure staff document the observation of inmates in SHOS as ordered by the clinician;
- Determine a method to ensure inmate requests are filed in the medical record in a timely manner;
- Provide training to staff to ensure that mental status exams (MSEs) are completed within the required timeframe for inmates on special housing status;
- Determine a method to ensure that inmates in mental health restraints are offered necessary services (e.g., bedpans, fluids, respiration/circulation checks, etc.) and those services are documented as required.

Corrective Action Plans

The CMA publishes a final report listing all survey findings and suggests corrective actions to be taken at the institutional level. The CMA also provides the institutions with a corrective action plan (CAP) tip sheet including guidelines for creating and submitting the CAP within 30 calendar days of the final report.

Institutional staff submits a written CAP that has been reviewed and approved by the OHS. Corrective action plans typically include in-service training, internal records monitoring, and physical plant improvements. Following CMA approval of the CAP, monitoring takes place for a period of no less than three months at which time the CMA will evaluate the effectiveness of corrective actions.

Following the initial monitoring period, the CMA requests the institution provide documentation of the corrective actions taken, including the monitoring tools for review. Based on this review staff will conduct either an on-site or off-site review and report the status of findings.

Based upon multiple institutions submitting inadequate monitoring, the CMA implemented a new procedure to review the initial monitoring by institutional staff after 30 days.

This process has been beneficial in determining if monitoring efforts are sufficient and allows the CMA to provide institutional staff with suggestions for improvement to increase the likelihood that findings will be monitored correctly. This fiscal year the CMA completed a total of 15 CAP assessments; 9 on-site and 6 off-site record reviews. The following is a complete breakdown of the CAP activities of the CMA during FY 2013-14.

FY 2013-14 Corrective Action Plan (CAP) Assessments **(*Occurred in FY 2014-15)**

Institution	Survey Date	Total Findings	1st CAP Assessment	2nd CAP Assessment	3rd CAP Assessment	4th CAP Assessment	Open Findings
Zephyrhills	May 2013	17	November 2013	April 2014	July 2014*	November 2014*	CLOSED*
Union	June 2013	52	January 2014	June 2014	September 2014*		CLOSED*
Jefferson	July 2013	72	February 2014	June 2014	October 2014*		2
Cross City	August 2013	17	February 2014	May 2014	September 2014*		CLOSED*
Suwannee	August 2013	70	March 2014	May 2014	November 2014*		13
Santa Rosa	September 2013	76	June 2014	October 2014*			3
SFRC South Unit	October 2013	94	May 2014 June 2014	September 2014*			13
Martin	November 2013	55	May 2014	September 2014*			40
Homestead	December 2013	22	May 2014	September 2014*			1

Committee Activities

Medical Review Committee

Per section 945.6032, Florida Statutes, the CMA is required to appoint a medical review committee to provide oversight of DOC's inmate health care quality management program. As part of this responsibility, CMA staff review all DOC amendments to the quality management program prior to implementation. Additionally, the CMA staff attended Quality Management meetings with DOC and the private contractors in November 2013 and June 2014. During these meetings DOC, Wexford, and Corizon presented a summary of the findings from their bi-annual quality reviews.

Quality Management Committee (QMC)

The primary focus of the QMC is a quality review of DOC's mortality review process to ensure the effectiveness of the self-evaluation of the quality of care provided during sentinel events. The QMC's mission is to provide feedback to DOC and the contractors about the efficacy of the process they use to identify health care deficiencies and provide for corrective actions.

The QMC is composed of a licensed physician committee chair and three volunteer health care professionals including one representative from the CMA Board. The committee held its first meeting in May 2014 with DOC and Corizon representatives. The QMC submitted suggestions for improved communication, documentation, and data tracking between DOC and the independent contractors and evaluated four mortality reviews.

Future meetings will include representatives from the other health care contractors. Annually, the QMC will hold one meeting to review a sampling of suicide cases occurring in the past year. The QMC will continue to meet on regular basis and analyze the mortality trends throughout Florida's prison system to provide valuable oversight of DOC's quality management program.

Budget and Personnel Workgroup

The CMA is required to advise the Governor and Legislature on cost containment measures and make recommendations on the inmate health services budget. In December 2013, two citizen volunteers chosen for their budgetary expertise met with the CMA to analyze the inmate health services legislative budget request (LBR) from DOC. The workgroup acknowledged the success of DOC's efforts to reduce pharmaceutical costs through the implementation of the 340B Specialty Care Program (HIV/STD) with the Department of Health and utilizing generic brand medications. Seeing no further areas for major cost-saving initiatives, the CMA advised the Governor in January 2014, of its support for a price level increase of $1,331,495 in health services drug costs as part of the FY 2014-15 inmate health services LBR of $356,808,439.

In FY 2013-14, DOC's inmate health services funding totaled $336,209,648 and included 136.5 positions. DOC contracts with Corizon to provide health care services at a single capitation rate of $8.4760 per inmate, per day based on the average monthly number of inmates and a rate of $8.4242 with Wexford.

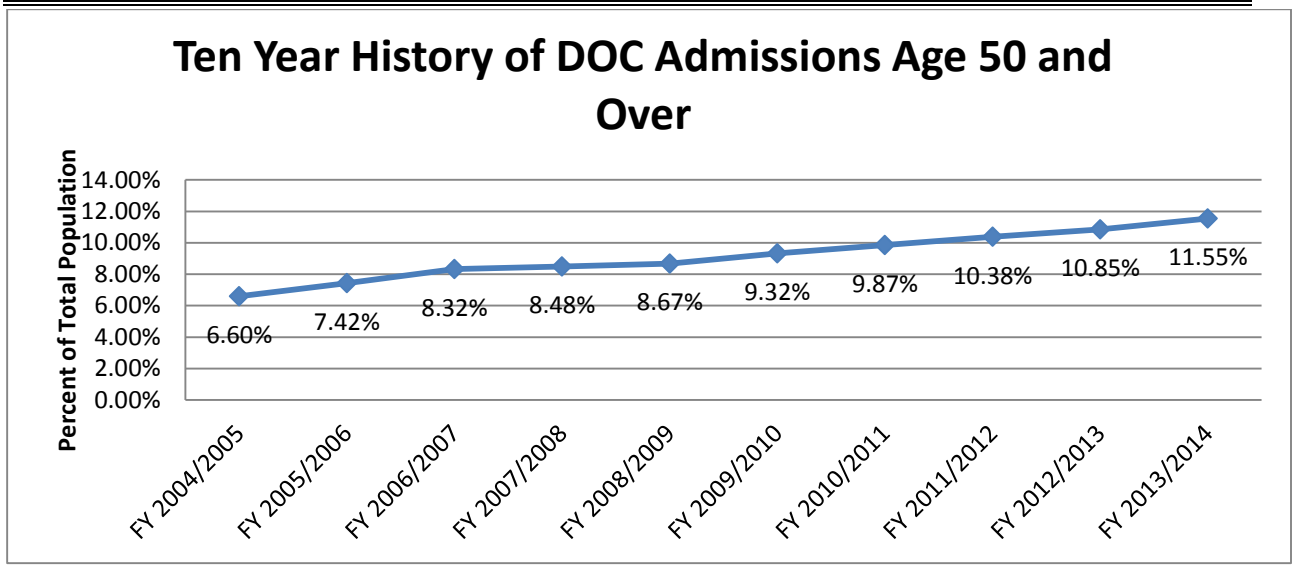
2013-14 REPORT ON ELDERLY OFFENDERS

In 1999, the Florida Corrections Commission and House of Representatives Committee on Corrections study of elderly and aging inmates required that the Correctional Medical Authority (CMA) and the Department of Corrections (DOC) submit annual reports to the Legislature providing information on elderly offenders (age 50 and over) within the correctional system. Pursuant to section 944.8041, Florida Statutes, this report provides a description of the status and treatment of Florida's elderly inmate population. The data presented on Florida inmates in this report is provided by DOC's Bureau of Research and Data Analysis and the Office of Health Services.

Status of Elderly Inmates

As of June 30, 2014, the total inmate population in Florida was 100,942 with more than 20% (20,753) of these inmates age 50 and over. Nationally, the elderly population makes up only 16% of the 2.5 million inmates in the United States[5]. Of the elderly inmates currently in the Florida prison system, 6,300 are projected to die while incarcerated. In FY 2013-14, there were 3,748 aging inmates admitted to DOC accounting for over 11.5% of all admissions. A look at the past ten years of elderly admissions reveals an ongoing trend of an increasingly older inmate population.

[5] Florida Tax Watch Research Institute, Inc. (2014). *Florida's Aging Prisoner Problem* (September 2014). Tallahassee, FL: McCarthy, Dan.



2013-14 Elderly Admissions

In FY 2013-14, the typical elderly admission was a white male almost 56 years of age. The majority of admissions had previous contact with DOC, and most of the commitments were for non-violent offenses, often relating to drug charges. There were no significant changes noted in the typical elderly admissions from the previous year. The table below is an illustration of the elderly admissions for FY 2013-14.

2013-14 Elderly Admissions	
Type	**Percentage**
Male	91%
Female	9%
Prior Admissions	62%
Violent/Sexual Offenses	29%
Non-violent Offenses	71%
White	57%
Black	40%
Other Races	3%

2013-14 Elderly Population

In FY 2013-14, the population of elderly inmates consisted of predominantly white males between the ages of 50 and 60. Almost half of the older population had no prior prison commitments. These trends are similar to the published data from the last fiscal year. The

demographics of this elderly population are presented in the following tables:

Elderly Population		
Category	**June 30, 2014**	
Gender	**20,753**	**100.0%**
Male	19,624	94.6%
Female	1,129	5.4%
Race		
White	11,340	57.8%
Black	8,728	44.5%
Other	685	3.5%

Elderly Population		
Age Breakdown		
50-55	10,767	54.9%
56-60	5,125	26.1%
61-65	2,270	11.6%
66-70	1,701	8.7%
71-75	563	2.9%
76+	327	1.7%
Prior DC Prison Commitments		
0	9,590	46.2%
1	3,298	15.9%
2	2,220	10.7%
3	1,778	8.6%
4+	3,849	18.6%
Data Unavailable	18	

Elderly Population by Offense Type on June 30, 2014		
Type of Offense	**Number**	**Percent**
Murder, Manslaughter	4,325	20.8%
Sexual Offenses	4,479	21.6%
Robbery	1,938	9.3%
Violent Personal Offenses	1,988	9.6%
Burglary	2,494	12.0%
Theft/Forgery/Fraud	1,510	7.3%
Drug Offenses	2,670	12.9%
Weapons	402	2.0%
Other	944	4.6%

Elderly inmates are housed in the majority of institutions based on their custody level and medical status and typically remain a part of the general population. The chart below lists the institutions with the largest population of elderly inmates.

Largest Elderly Population by Institution			
Institution	**Total Population**	**Over 50**	**Percent**
Blackwater CF	1,993	425	21.3%
South Bay CF	1,893	456	24.1%
Union CI	1,869	1393	74.5%
Okeechobee CI	1,790	470	26.3%
Everglades CI	1,636	569	34.8%
Wakulla Annex	1,630	428	26.3%
Hardee CI	1604	506	31.5%
Dade CI	1,562	581	37.2%
Wakulla CI	1,485	433	29.2%
SFRC South	561	404	72.0%

Treatment of Elderly Inmates

DOC reports that the elderly population accounts for close to half of all episodes of care while representing just over 20% of the total prison population. Below is a breakdown of impairments in elderly inmates.

Elderly Population Impairment Breakdown						
Impairment	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Visual	41	18	27	18	18	122
Hearing	40	30	33	21	25	149
Physical	225	202	163	98	176	864
Developmental	15	8	1	4	4	32
Total	**321**	**258**	**224**	**141**	**223**	**1,167**

Florida's prison system provides comprehensive medical care to elderly inmates within the correctional system. Care includes special accommodations and programs, medical passes, and skilled nursing services for chronic and acute conditions as well as palliative care for terminally ill inmates. The table below illustrates the type and number of medical services provided to elderly inmates in FY 2013-14.

Active Medical Passes for Elderly Population						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Adaptive Devices	567	442	320	178	244	1,751
Attendant	21	22	24	20	25	112
Low Bunk	3,919	2,881	1,650	816	644	9,910
Guide	15	8	1	4	4	32
Hearing Aid	2	5	5	6	8	26
Pusher	19	10	18	6	13	66
Special Shoes	109	69	46	29	27	280
Wheelchairs	95	98	90	60	103	446
Total	**4,747**	**3,535**	**2,154**	**1,119**	**1,068**	**12,623**

Inmates with chronic illnesses are enrolled in various specialty clinics that provide ongoing monitoring and treatment for chronic conditions. Over 40% of those assigned to chronic illness clinics are age 50 or older. The elderly population accounts for almost 30% of all sick call visits and approximately half of emergency visits. These percentages remain consistent with clinic enrollments and health care contacts over the past five years. The tables below show the total number of clinic visits for all age groups in the elderly population.

Elderly Inmates Assigned to Chronic Illness Clinics						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Cardiovascular	4,444	3,428	2,110	1,163	936	12,081
Endocrine	1,408	1,106	673	414	354	3,955
Gastrointestinal	1,510	1,343	745	229	88	3,915
Immunity	568	307	135	43	9	1,062
Miscellaneous	423	339	225	147	161	1,295
Neurology	350	197	98	37	29	711
Oncology	102	121	97	87	93	500
Respiratory	863	638	424	230	213	2368
Tuberculosis	234	147	63	21	20	485
Total	**9,902**	**7,626**	**4,570**	**2,371**	**1,903**	**26,372**

Elderly Inmates Health Care Contacts						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Multiple Clinics	2,693	2,223	1,415	759	644	7,734
Sick Call Visits	115,284	80,454	45,835	22,480	18,904	282,957
Emergency Visits	1,830	1,336	778	400	426	4,770
Total	**119,807**	**84,013**	**48,028**	**23,639**	**19,974**	**295,461**

Findings and Recommendations

The CMA's report on the status of elderly offenders continues to show that older inmates have more health problems and generally consume more health care services than younger inmates. The demands of caring for the elderly continue to have an impact on corrections' health care costs. According to The National Institute of Corrections, the overall cost of incarceration for inmates over 50 is as much as three times higher than for the younger population mostly due to the difference in health care costs.[6] Across the country the impact of rising health care costs, especially for elderly inmates, is similar to the impact in Florida.

Florida's elderly prison population has increased almost 5% over the last 5 years and is expected to gain over 6,000 inmates by the end of the next fiscal year. Considering the trend of increasing elderly inmate populations and health care costs, the CMA supports medical passes and special accommodations (e.g., low bunks, special shoes, wheelchairs, etc.) provided to older inmates housed in DOC's general population. DOC policies ensuring periodic screenings, regularly scheduled clinic visits, and the establishment of specific facilities for elderly inmates in need of a higher level of care improves the health of elderly inmates. Improved health status within the aging population will serve as a positive cost-containment measure.

It is recommended that DOC continue to examine and consider the needs of inmates over 50 when establishing standards of care criteria for the private health care providers. Additionally, reporting of detailed health care costs for aging inmates would be beneficial for analysis of projected needs to adequately care for the elderly population in the coming years.

[6] Florida Tax Watch Research Institute, Inc. (2014). *Florida's Aging Prisoner Problem* (September 2014). Tallahassee, FL: McCarthy, Dan.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/20/15
Meeting Date

Bill Number (if applicable)

Topic Correctional Medical Authority Update

Amendment Barcode (if applicable)

Name Jane Holmes

Job Title Executive Director

Address 400 S. Monroe St., Ste. # 705
Street
Tallahassee, FL 32399
City *State* *Zip*

Phone (850) 717-9500

Email jane.holmes-cain@eog.myflorida.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Correctional Medical Authority

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

Florida TaxWatch
center for Smart Justice

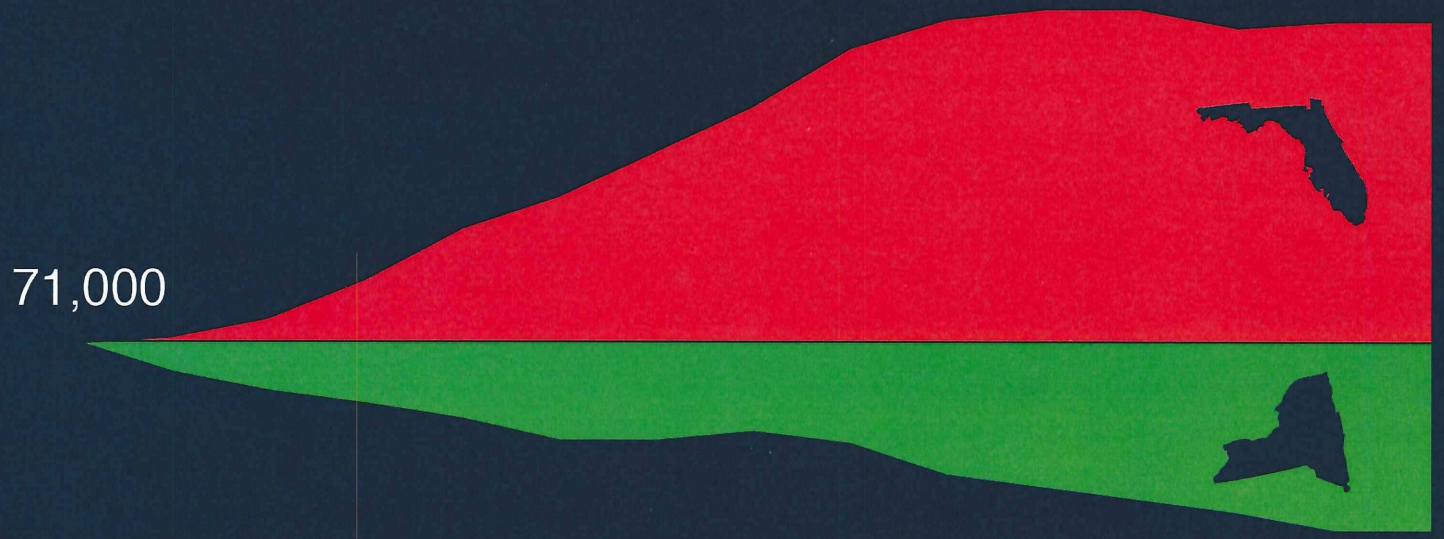
Florida's Aging Prisoner Problem:
The Cost of Elderly Inmates

Robert Weissert, Esq.
Chief Research Officer

Elle Piloseno
Research Analyst

PRISON POPULATION CHANGE SINCE 2000

Florida TaxWatch
center for Smart Justice



POPULATION COMPARISON (2014)

Florida TaxWatch
center for Smart Justice

19,746,227

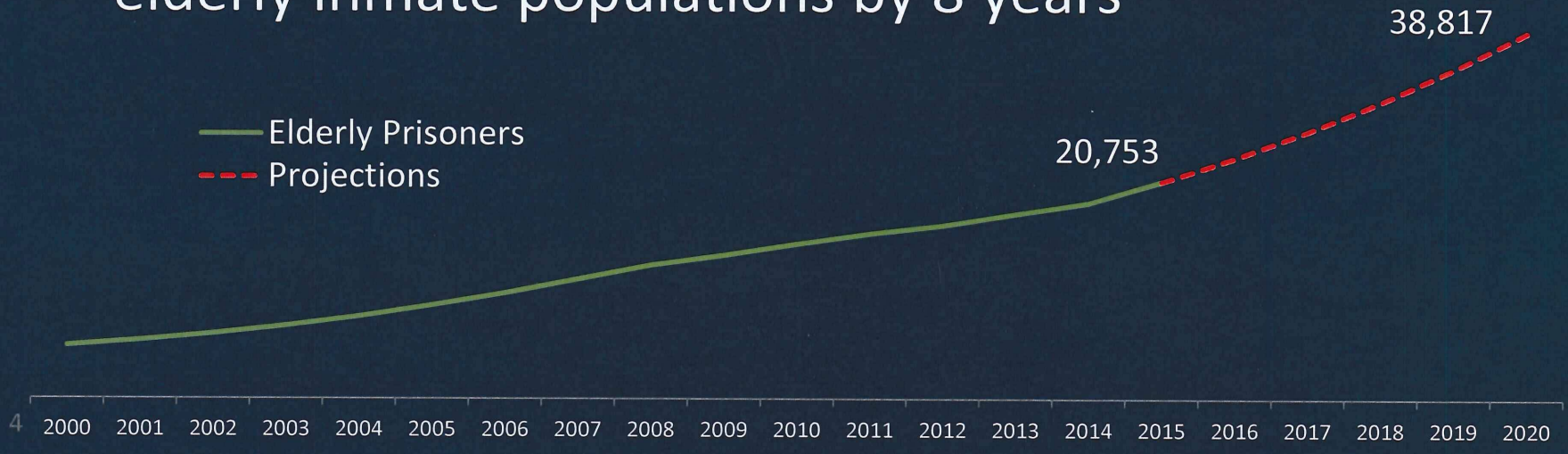
19,893,297

FLORIDA'S PRISONS ARE EXPANDING & GRAYING

Florida TaxWatch
center for Smart Justice

- Florida's elderly prison population expands *three times as quickly* as the total prison population.

- By 2020 the elderly prison population will have almost doubled, beating national projections for elderly inmate populations by 8 years



WHAT IS "ELDERLY"?

Florida TaxWatch
center for Smart Justice

F.S. 944.02:

"Prisoners age 50 or older in a state correctional institution or facility operated by the Department of Corrections".

SENIOR INMATES ARE EXPENSIVE

Florida TaxWatch
center for Smart Justice

- Nationally, inmates over 50 cost 2-3 times as much to incarcerate as the average prisoner.

<u>In Florida:</u>

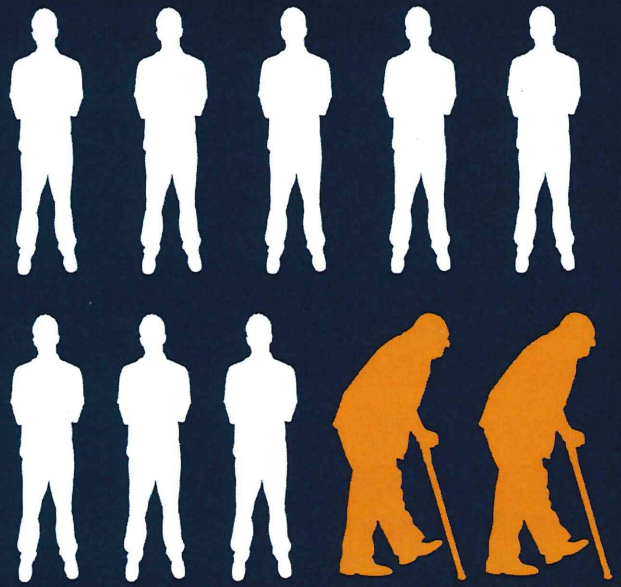
Inmates Over 50 = $36,000-$54,000

Average Inmate = $18,000

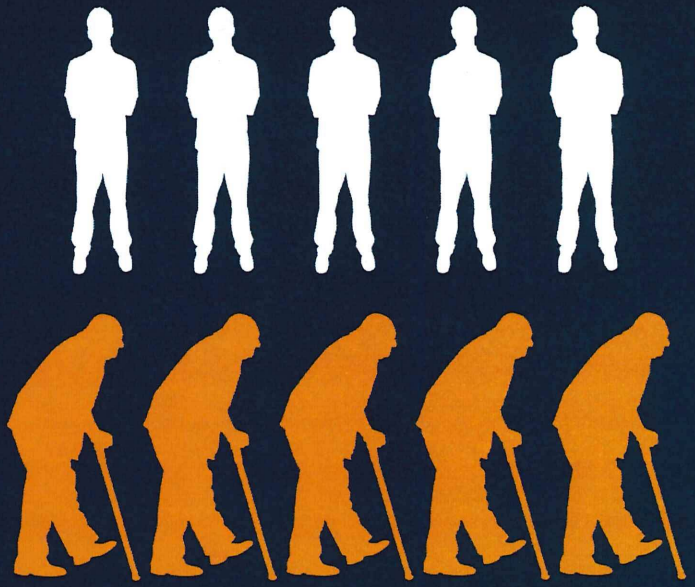
SENIOR INMATES HAVE COSTLY HEALTHCARE NEEDS

Florida TaxWatch
center for Smart Justice

PRISON POPULATION
(percentage)



HEALTHCARE COSTS
(percentage)

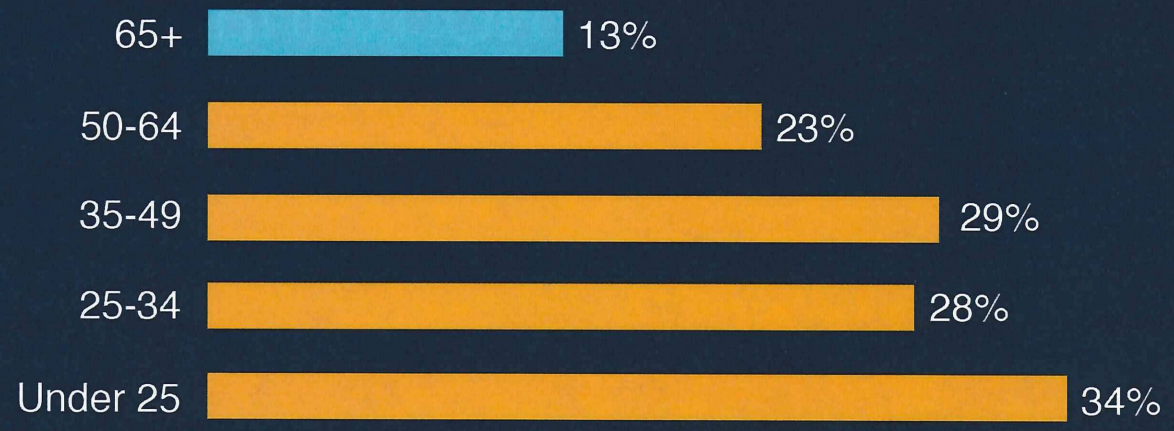


OLDER INMATES ARE A LOWER RISK

Florida TaxWatch
center for Smart Justice

- Only 13% of released inmates over 65 recidivate within three years.

- Younger Inmates tend to pose a greater risk of recidivism, with 34% of releasees recidivating within three years.



3 Year Recidivism Rates

FLORIDA HAS THOROUGH REVIEW PROCESSES

Florida TaxWatch
center for Smart Justice

- The Florida Commission on Offender Review (formerly the parole commission) considers the following during discretionary release hearings:
  - Offender risk to public safety
  - Criminal history and behavior in prison
  - Testimonies for/against the release of eligible inmates
  - Offenders' reentry plans

SOLUTIONS

Florida TaxWatch
center for Smart Justice

1. Extend Conditional Medical Release eligibility to elderly, sick inmates not within 180 days of death

2. Implement a Supervised Conditional Elderly Release Program (SCERP)

BENEFITS & SAVINGS: CONSERVATIVE ESTIMATES

Florida TaxWatch
center for Smart Justice

- Cost-savings through SCERP:

  $27.2 million - $168 million annually

- Additional benefits:
  - Decreasing overall prison populations by up to 20 percent.
  - Rededicating bed space and resources for dangerous offenders
  - Alleviating healthcare burdens from state corrections budgets

Florida TaxWatch

Florida's Aging Prisoner Problem

SEPTEMBER 2014

106 North Bronough Street, Tallahassee, FL 32301 floridataxwatch.org o: 850.222.5052 f: 850.222.7476

John B. Zumwalt, III
Chairman

Dominic M. Calabro
President & Chief Executive Officer

September 9, 2014

Dear Fellow Taxpayer,

Florida's prison population is among the largest in the United States, and disproportionately large, given the state's population. Furthermore, estimates show that the population will continue to grow much faster than other similar states in the foreseeable future. As the state's prison population rises, it will be accompanied by ballooning costs, especially health care costs, that are already overwhelming the Florida Department of Corrections (DOC), and creating crippling costs for taxpayers.

Previous Florida TaxWatch research has produced constructive policy recommendations that would safely reduce the prison population. These policies have been shown to be effective at reducing costs in other states without jeopardizing public safety, and, if implemented by the Legislature and Governor, would help address many of the issues facing Florida's taxpayers.

However, the sheer number of inmates is not the only concern. As prisoners age, they put a severe strain on the state budget, largely due to the high costs of providing health care to long-term, elderly, and infirmed inmates. Florida's current criminal justice policies tie the hands of the DOC and keep the taxpayers of Florida financially responsible for housing and caring for infirmed inmates incarcerated after they are no longer a threat to public safety.

Once again, other states and the federal government have faced similar issues and forged policy solutions. The path they have laid can be followed to benefit Florida taxpayers.

Florida TaxWatch has examined options for the DOC to reduce the costs of the existing system and providing increased security for our communities by reducing crime and recidivism rates, all without harming public safety. Past recommendations have included examining sentencing reform, vocational, educational and liftestyle training, and reentry and reintegration programs. To solve the current health care spending concern, this Florida TaxWatch report analyzes this cost driver and provides recommendations to reduce the elderly prisoner population, saving taxpayers' hard-earned money without compromising the safety of Florida communities.

Sincerely,

Dominic M. Calabro

Dominic M. Calabro
President & CEO

Introduction

Florida passed very tough crime laws in the 1990s. Drug wars, tourist murders, and the shooting deaths of law enforcement officers spurred legislators to adopt strict sanctions for crime which removed parole; required 85 percent sentence completion; added mandatory minimum sentences for drugs and violent crimes; lengthened sentences for habitual offenders; imposed 10/20/Life punishments for gun crimes; and added involuntary civil commitment for convicted sex predators. Life felonies, which previously included parole review hearings, now carry life without parole (LWOP) sentences. This development is particularly important in Florida, one of three states where a jury of six, instead of 12, can sentence a convicted felon to Life Without Parole (LWOP).[1]

These strict criminal justice policies had immediate and long-term consequences on corrections issues in Florida. The general prison population shot up dramatically, the length of sentences increased, and the number of prisoners with LWOP sentences rose to the highest in America. Elderly prisoners, no longer paroled when advancing age renders them a low risk, remain in prison cells.

These changes have brought to the forefront urgent issues that must be addressed for Florida's taxpayers. As the average age of the prison population rises and the number of elderly prisoners multiplies, the cost of lenthy sentences and prisoner healthcare needs threaten a substantial rise in Florida's Corrections budget; however, there are options for reform that may help keep costs from overwhelming taxpayers.

1 Florida law permits a jury of six to impose a LWOP sentence. Connecticut and Utah are the only other states to allow six-member juries to sentence to LWOP. See, "Bill Would Double Jury Size for Life Felonies," The Florida Bar News, April 4, 2014. See also, Senate Bill 98 "Bill Analysis and Fiscal Impact Statement," February 11, 2014.

Florida's Prison Population

OVERALL POPULATION

Defined in *Florida Statutes* as those prisoners within the Florida Department of Corrections (FDOC) system over the age of 50, the elderly prisoner count increases every year, by an average of greater than 1,000 prisoners. The tables to the right show that between 2000 and 2014, the elderly prison population grew from 5,605 to 21,002, at an average increase of 9.9 percent per year, a rate more than three times higher than the general prison population.

Furthermore, the chart shows that while the overall prison population growth in Florida has steadied out during the last 5 years at about 100,000–102,000 prisoners, the elderly prison population has grown by more than one third (38 percent) in the same time frame, and has yet to find a ceiling.[2]

Historical Florida Prison Population Including Specific Age Groups[2]

Year	Prison Pop	50-59	60+	Total 50+
2000	71,233	4,243	1,362	5,605
2001	72,007	4,720	1,452	6,172
2002	73,553	5,299	1,553	6,852
2003	77,316	5,928	1,763	7,691
2004	81,974	6,759	1,937	8,696
2005	84,901	7,724	2,159	9,883
2006	88,576	8,727	2,451	11,178
2007	92,844	9,825	2,833	12,658
2008	98,192	10,946	3,197	14,143
2009	100,894	11,671	3,530	15,201
2010	102,232	12,491	3,895	16,386
2011	102,319	13,179	4,313	17,492
2012	100,527	13,675	4,693	18,368
2013	100,884	14,469	5,131	19,600
*2014	102,467	15,308	5,694	21,002

* Data from 2014 taken from June 10, 2014 estimates.

As of June 2014, the data show that Florida has 5,694 prisoners at least 60 years of age, 1,091 prisoners at least 70 years old, 130 octogenarians, and 10 nonagenarians.[3] Among the octogenarians, 40 percent were sentenced to terms of years as opposed to life without parole, and 19 have release dates in the next 3 years. Florida also has two prisoners aged 92, who rank at the top of the oldest prisoners in the US.[4]

Further evidence of the graying of Florida's prisons is demonstrated by analysis of the average age of prisoners (chart, next page). From 1996 to 2013, the median and mean ages have both increased significantly, and the mean age has increased more than the median age, indicating a shift to an increasingly older population.

2 Corrections Offender Network: Offender Information Search, Florida Department of Corrections, June 10, 2014.

3 *Ibid.*

4 Drayton Curry, 92, Nation's Oldest Federal Prisoner: Obama AWOL on Clemency Request," The Village Voice, Sep 2011.

Average and Median Age of Florida Prisoners

Year	Average Age	Median Age
1996	33.3	32.3
1997	33.2	32
1998	33.7	33
1999	34.1	33
2000	34.4	34
2001	34.8	34
2002	35.2	34
2003	35.5	35
2004	35.8	35
2005	36.2	35
2006	36.6	36
2007	39.9	36
2008	36.9	36
2009	36.9	36
2010	37.0	36
2011	37.2	36
2012	37.7	36
2013	38.0	36

Source 2009-2013: "Agency Statistics: Inmate Population - Current Inmate Age", Florida Department of Corrections, June 30th estimates, 2009-2013.
Source 1996-2008: "Annual Report: Inmate Population on June 30th - Current Inmate Age", Florida Department of Corrections, 1996-2008.

COMPARISON TO OTHER STATES

To gain a full grasp of the prison population explosion in Florida from a population and prison count, a comparison to New York is appropriate. Going back to 2000, Florida's total population was just under 16 million, while New York's was just under 19 million.[5] Both had equivalent prison populations of about 70,000.[6]

Fourteen years later, Florida and New York have nearly identical total populations, but Florida's prison population is 102,467, while New York's prison population is 54,600;[7] and there are 9,200 elderly prisoners in New York compared to 20,680 in Florida, all of which is directly attributable to different philosophies on criminal justice.[8]

A 2012 study by The Sentencing Project reported that Florida leads the country with almost 8,000 prisoners sentenced to Life Without Parole (LWOP),[9] and no other state is close.
By comparison, Texas had 538, and New York only 246. By June 2013 the number of prisoners in Florida with death or life sentences stood at 12,667. As would be expected, the increase in life sentences and terms of years is keeping prisoners behind bars into their senior years, leading to the substantial increase in elderly prisoners shown above.

It is not just the increased life sentences which are driving prison populations up. As a result of Florida's tough-on-crime laws, the length of prison sentences in Florida has increased more than any other state.[10]

5 Population Distribution and Change:2000 to 2010. U.S. Census Bureau 2010 and Census 2000.

6 State of Recidivism: The Revolving Door of America's Prisons, Pew Center on the States, April 2011.

7 New York State Department of Corrections and Community Supervision Announces prison Reforms That Will save Taxpayers more than $30M Following Decline in Crime rate and Inmate Population," July 26, 2013.

8 "If the Risk is Low, Let them Go": Efforts to Resolve the Growing Numbers of Aging Behind Bars, Truthout January 19, 2014.

9 "Life Goes On: The Historic Rise in Life Sentences in America," The Sentencing Project 2013.

10 Time Served: The High Cost, Low Return of Longer Prison Terms, PEW Study June 2012.

Average prison time served in Florida has grown by 166 percent, meaning that a typical felon now serves 22 months longer than they would have served two decades earlier. The Sentencing Project study stated that Florida "sticks out like a sore thumb" and has done little to "rein in their sentencing and corrections costs."

For context purposes, the elderly prison population nationwide constitutes 16 percent of the 2.5 million prisoners in the US. In Florida, that percentage has now reached over 20 percent, which makes Florida the state with the greatest percentage of elderly prisoners in the nation. Prison in Florida is no longer simply a detention facility for young people, it is largely becoming a repository for elderly prisoners serving extended sentences.

Healthcare Costs Threaten State Budget

The fiscal consequences of a rapidly aging prison population pose an ominous threat to Florida taxpayers. Not only will it costs hundreds of millions of dollars per year to pay for medical costs of prisoners who pose little threat to public safety, but it will also distract from the corrections mission, divert needed resources, and reduce public safety.

FDOC provides the following comments in their *2012 Annual Report* regarding the elderly prison population and projected health care costs:

> *"Although Florida does not track health care costs by age, utilization data shows that elderly inmates account for a disproportionate share of hospital services. In FY 2011-2012, elderly inmates accounted for 46.6% of all episodes of care and 49% of all hospital days…The dramatic increase in the elderly population, and the related cost of care for this population, presents one of the biggest challenges for FDOC over the next 15-20 years."*

The potential fiscal consequences of providing health care to a large elderly prison population are staggering. The National Institute of Corrections estimates that states spend on average $70,000 per year to incarcerate someone age 50 or older, nearly three times what it costs to house a younger prisoner, largely because of the difference in health-care costs.[11] Other studies are in accord, including a 2012 comprehensive analysis by the American Civil Liberties Union, which concluded the annual average cost to house a prisoner is $34,135, but rises to $68,270 if the prisoner is age 50 and older.[12]

11 "State Initiatives to Address Aging Prisoners", Kevin McCarthy and Carrie Rose, Office of Legislative Research (OLR), March 4, 2013.

12 "At America's Expense: The Mass Incarceration of the Elderly" ACLU 2012

These studies point out that arthritis, diabetes, hepatitis C, cancer, hypertension, ulcer disease, AIDS, dementia, Alzheimer's disease, and prostate problems are common chronic ailments among elderly prisoners. The treatment and medicines for these illnesses are very expensive, and the bill goes directly to Florida taxpayers. Florida prisons, built to insulate law-abiding citizens from dangerous and aggressive felons, are being transformed into intensive care units and hospices.

The federal government, which also has a significant elderly prison population, recognizes the gravity of the situation, as demonstrated by this excerpt from a Department of Justice Inspector General (DOJ IG) Report:

> *"While the Department has taken initial steps to address its reduced budget, the Department must also have in place an innovative and transparent strategic vision for how to fulfill its mission in the long term without requiring additional resources. Nowhere is this problem more pressing than in the federal prison system, where the Department faces the challenge of addressing the increasing cost of housing a continually growing and aging population of federal inmates and detainees."*[13]

The report from the DOJ IG went on to proclaim that "we are on an unsustainable path," and also found that, like Florida, the Federal Bureau of Prisons does not track the costs related to the care for aging and sick inmates.

Extrapolating the cost of elderly health care from published FDOC information is possible. FDOC reports that elderly patients accounted for 49 percent of all hospital days in 2012. Assuming hospitalization days are representative of overall prison health care costs, the elderly prison population was responsible for approximately half of the $408 million prisoner healthcare costs in 2012, which averages to $11,000 per year solely for the health care of elderly prisoners. The remaining 82,209 prison population is under the age of 50, and their health care costs average approximately $2,500 per prisoner.

This rough analysis indicates that elderly prisoners cost four times as much as non-elderly prisoners. Furthermore, this estimate is very likely a conservative one, as a "hospital day" for an elderly patient likely requires more doctor and nurse supervision, more drugs, more physical therapy, and more tests than younger prisoners.

These estimates are congruent with medical costs estimates from prison studies conducted around the country, and from medical experts regarding prison healthcare costs for the

13 "Cost Savings and Efficiencies at the Department of Justice", Statement of Michael E. Horowitz, Office of the Inspector General, United States Department of Justice, April 10, 2013.

elderly (see text box, right). These experts report elderly prisoners create cost multipliers of 2-8 times that of prisoners below 50 years of age.

Other studies suggest the costs to imprison elderly felons are even higher. The American Civil Liberties Union released a detailed report in 2012 which offered a low estimate of $28,362; a middle estimate of $66,294; and a high estimate of $104,436.[14] A Louisiana report found that the Angola Prison houses a group of elderly prisoners with annual medical costs exceeding $100,000 per inmate.[15] This led the Warden of Angola, Burl Cain, to say: "When I came here and saw the elderly population, I said why are they here? Our name is Corrections to correct deviant behavior, but there's nothing to correct in these guys; they're harmless."[16]

A recent study from the Michigan Department of Corrections reported a 65 year old prisoner with $316,420 in medical bills in 2013.[17] According to this report, the top 10 prisoners with the highest health care costs averaged more than $220,000 per prisoner for health care or mental health care treatment. There is no reason to believe these types of high-cost elderly patients are not present in every state prison system, and even more pronounced in Florida because of its substantial elderly population.

FDOC's annual reports contain additional information about corrections budgets and prisoner health care costs. The table on the next page shows the overall FDOC budget, with specific line item for healthcare costs, since 2000.

Examples of Annual Elderly Prisoner Health Care Costs in Other States

A Virginia study in 2012 found elderly prison costs were $5,372 compared to $795 for those less than 50 years of age, a 6 times cost multiplier.[1]

A 2008 Georgia study found that care for those 65 and older costs $8,565 compared to $961 for those under 65.[2]

A 2010 Texas study reported health care costs of $4,853 per elderly prisoner, and $795 for younger prisoners.[3]

A 2010 Michigan study found elderly care was $11,000 annually, and more than 4 times that of an offender in their twenties.[4]

1 Virginia Department of Corrections, "Older Inmate Population: Managing Geriatric Issues" October 2011.

2 "Government Explores Early Release for More Aging Prisoners," LA Times November 12, 2013.

3 "Elderly inmates are putting a burden on Texas taxpayers," Houston Chronicle, May 16, 2011.

4 "Michigan's Prison Health care: Costs in Context," Michigan Senate Fiscal Agency, November 2010.

14 "At America's Expense: The Mass Incarceration of the Elderly," American Civil Liberties Union Report 2012.

15 "Aging Prisoners Costs Put Systems in Nationwide in a Bind," USA Today, July 11,2013.

16 "At America's Expense: The Mass Incarceration of the Elderly," American Civil Liberties Union Report 2012.

17 "Michigan gets serious about high cost of prisons," The Center for Michigan, April 15, 2014.

The FDOC budget has grown by $560 million (35 percent) from 2000-2012. Health care costs have grown by $176 million, or 76 percent, in that same period. Health care costs are growing at more than twice the rate of overall corrections spending.

How much will FDOC budgets rise to meet the necessary costs to incarcerate elderly prisoners? That will depend specifically on two variables, both of which are also escalating.

The first factor is the increasing cost of health care and mental health treatments for the types of ailments most common to aging prisoners. Medical costs for treating hepatitis C alone could swamp FDOC budgets, as a new treatment for the disease is projected to cost upwards of $100,000 per patient (see case study on next page). Additionally, mental health treatment is a particular problem in Florida, where it is estimated that minimum care for one mentally ill prisoner costs more than $60,000.[18]

A second factor determining health care costs will be the longevity of prisoners. Life expectancy in the U.S., now 81 for women and 76 for men, has steadily increased over time.[19]

Must Florida provide expensive medical, mental and drug treatments to prisoners? Executive, legislative and judicial leaders will have to answer these controversial questions, but an imposing hurdle will be the 8th amendment ban on cruel and unusual punishments, which the U.S. Supreme Court has interpreted to mean that state prison care cannot show "deliberate indifference to serious medical needs" of prisoners.[20] The Illinois precedent will speak loud, and it is hard to imagine state and federal courts permitting a state to withhold from an afflicted prisoner a treatment capable of curing a life-threatening disease.

Corrections Budget in Florida vs. Heathcare Costs

Year	DOC Budget	Reported Healthcare Costs
2000	$1.58 b	$232 m
2001	$1.63 b	$246 m
2002	$1.62 b	$257 m
2003	$1.68 b	$280 m
2004	$1.79 b	$307 m
2005	$1.88 b	$315 m
2006	$2.06 b	$340 m
2007	$2.13 b	$373 m
2008	$2.29 b	$424 m
2009	$2.24 b	$394 m
2010	$2.30 b	$414 m
2011	$2.39 b	$409 m
2012	$2.14 b	$408 m
2013	$2.07 b	$295 m

Source: Florida Department of Corrections. Annual Reports: Agency Statistics: Budget, 2000-2013.

18 "From Prisons to Hospitals-and Back: The Criminalization of the Mental Illness," Prison policy initiative

19 US Life Expectancy Map 2013, National Geographic.

20 Estelle v. Gamble, 429 U.S. 97, 104 (1976).

CASE STUDY - SOVALDI

A new antiviral drug treatment for hepatitis C, known as Sovaldi, was approved in early 2014 for the treatment of this life-threatening, blood-borne infection common in prisons because it can be passed by needles used for drug injections, tattoos and body-piercing.[1] The number of prisoners in Florida with hepatitis C is not reported, but national estimates indicate anywhere from 16–41 percent of prisoners carry this disease, and 12–35 percent are chronically infected.[2] Sovaldi is very expensive, approximately $1,000 per pill, and it takes months of treatment with the cost ranging from $65,000 to $170,000.[3] Sovaldi has a cure rate in some clinical studies of 95 percent, which is significantly higher than all other available treatments for hepatitis C.

Prior to 2014, state prison systems had not prescribed this medicine for prisoners. This is beginning to change. The Federal Bureau of Prisons began making Sovaldi available in February 2014,[4] and New York has begun using Sovaldi for prisoners with the most serious cases. Washington and Wisconsin are also beginning to use Solvaldi, and California is revising its prison health care policies to incorporate the use of the new drug.

Illinois corrections officials estimate the treatment will cost $61,000-$122,000 per prisoner, and they have as many as 3,750 prisoners who will need the drug. Cost estimates are $61 million in the first year. Illinois is facing great budget challenges, aggravated by these new corrections costs. A temporary tax has been requested, and if not granted, reports are as many as 15,500 inmates would be released to offset the cost of corrections.[5] The total prison population in Illinois is 49,154, or approximately half that of Florida.[6]

If Florida makes these drugs available to those afflicted with hepatitis C, health care costs will explode. Using the Illinois estimates leads to a cost of $122 million to treat hepatitis C in Florida prisons, and if higher national estimates are applied, there could be as many as 7,000 prisoners in Florida suffering from chronic hepatitis C, and needing the new costly treatments.

Such estimates lead to treatment costs in the $1 billion range. That is more than double the entire FDOC budget for prison health care.

---

1 "State approves prison hepatitis C drug, likely to cost millions," Herald-Review, April 22, 2014.

2 "Correctional Facilities and Viral Hepatitis," Centers for Disease Control and Prevention, April 22, 2014.

3 "Should Prisoners Get Expensive Hepatitis C Drugs?," The Pew Charitable Trusts, March 26, 2014.

4 "New Hepatitis Drugs Vex Prisons," Wall Street Journal, April 24, 2014.

5 "Illinois prisons to use costly hepatitis C drug," The Kansas City Star, April 18, 2014.

6 "Illinois Corrections numbers show record prison population," Journal Star, Sep 18, 2012.

Setting the Sovaldi issue aside, the final years of incarceration are the most expensive to taxpayers, so at more than $11,000 per year per prisoner, the addition of 2,500 elderly prisoners per year will add $30 million per year in health care costs. If the national average of $68,270 per year estimate is used, the annual cost to Florida taxpayers to incarcerate 20,750 elderly prisoners is $1.5 billion, or almost three-fourths of the current FDOC budget. These numbers become astronomical, and unsustainable, if new medical treatments and mental health requirements are added to cost spreadsheets.

Projections for Florida

As the statistics demonstrate, the elderly prison population has gone up every year since 2000 by an average of more than 1,000 prisoners per year, and exhibits a growth rate significantly exceeding that of the general prison population. The Florida Criminal Justice Estimating Conference (CJEC), which uses relevant real-time criminal justice data such as arrests, felony filings, and convictions to assess future prison population growth, projected in early 2014 that the total prison population in Florida in 2018 will be 104,960.[21] This constitutes minor prisoner increases over the next four years, and shows the rapid growth from the last decade has now steadied. CJEC does not estimate the elderly prison population subset within the total prison population projection, nor does the FDOC, but estimates can be extrapolated from existing data.

The variables below can be used to estimate where the elderly prison population will be at the end of FY2014-15:

- *Current prisoners aging up to 50*: The 35-49 age group presently housed in Florida prisons consists of 36,048 prisoners. Within this group, 4,452 prisoners are 48-49 years old. A quick survey of the first 200 names in the 48-49 age group reveals 23 percent have release dates in 2014 and 2015. Assuming this sample is representative, one fourth will be released in the next 20 months, leaving approximately 3,200 current prisoners who will remain imprisoned and join the elderly prisoner category by the end of 2015.
- *New elderly prisoner admissions in 2014-2015*: The FDOC annual report shows there were 3,349 elderly admissions in 2012; 3,452 in 2011; and 3,448 in 2010. A fair expectation from these statistics is about 3,400 elderly prisoner admissions per year in 2014 and 2015. Conservatively, this will add more than 6,000 new elderly prisoners by the end of 2015.

21 Criminal Justice Estimating Conference: Held November 20, 2013.

- *Elderly prisoner releases*. A quick survey of the first 200 names in the 50+ category shows 26 percent will be released in 2014-2015. Again assuming this sample is representative, approximately 5,100 elderly prisoners will leave the prison system by the end of FY2014-15.
- *Summing up*: The 20,750 elderly prison population in Florida today will gain approximately 6,000 new admissions by the end of 2015, age up about 3,200 prisoners, and release 5,100 prisoners. That equals a net gain of 4,100 elderly prisoners by the end of FY2014-15, or an increase of 200 elderly prisoners per month.

The addition of 4,100 elderly prisoners to the current population of 20,750 will take Florida to 24,850 elderly prisoners by the end of 2015. Assuming no interim policy changes to manage the elderly prison population, the number will further climb to 30,000 by 2018. Comparing this to national average predictions from the Wall Street Journal, which reports that "at current rates a third of all prisoners will be 50 or older by 2030,"[22] Florida will achieve this dubious distinction 10 years ahead of the rest of the nation.

Solutions/Options

The dilemma of expanding elderly prison populations and their high healthcare costs is not unique to Florida, but it is a relatively recent problem. Parole and compassionate release programs existed in Florida prior to 1995. That all changed, however, when Florida enacted a new law which removed parole, substituting in its place of a system requiring prisoners serve 85 percent of the sentence imposed. Life sentences from that point on were "for the rest of their natural lives, unless granted pardon or clemency."[23] All flexibility in Florida corrections has been removed, and there are no exceptions.

Federal, state and foreign jurisdictions are enacting early release programs for prisoners based on age, offense, medical condition, time served and public safety assessments. These initiatives, known by such terms as "geriatric parole," "compassionate release," "elderly parole," "medically recommended Intensive supervision," and "humanitarian release" have become the most common way for states to avoid enormous health care costs for aging prisoners by releasing aging and ailing prisoners who pose no risk to the public. Some advocates of early release programs also point to the compassionate aspects of releasing terminally ill and physically disabled prisoners in their last stage of life.

22 "Care for Aging Inmates Puts Strain on Prisons," Wall street Journal, January 27, 2012.

23 Florida Statutes 944.275

The policy rationale for releasing nonviolent elderly prisoners is clear. Elderly prisoners cost the most to incarcerate, but pose the least danger to public safety. The potential savings available are substantial, as a 1 percent reduction in Florida's prison population gained through early release of elderly prisoners could result in annual savings of $67 million. A five percent reduction would save more than $300 million.

UTLIZING CLEMENCY POWERS

One method for reducing prison sentences for the elderly is through executive clemency powers. Although this administrative prerogative is generally used sparingly by the President and Governors to prevent injustice or correct errors, it can be accessed to reduce sentences. President Obama recently announced his willingness to use his clemency authority to focus on federal felons serving long terms for drug offenses.

Under the revised clemency program, eligible prisoners would be those who have served at least 10 years, with no significant criminal history, that are non-violent low level offenders not associated with gangs, and with a good conduct record in prison.[24] The clemency office will be beefed up to allow quick review and action on those prisoners who meet the guidelines adopted. It is estimated that this could result in the release of thousands of non-violent drug offenders, and save hundreds of millions of dollars.[25]

The administrative requirements surrounding President Obama's decision to use his clemency power to reduce certain federal drug sentences does serve to remind state governors that while they could institute similar guidelines and reduce the sentences of specific classes of prisoners, like those very old or terminally ill, it remains highly unlikely. States do not have the legal assets of the Department of Justice to review large numbers of clemency requests, and clemency cannot become a de facto parole board in a state that has abolished parole.[26] However, clemency could be used for unique cases of very old and ailing prisoners, to show them compassion, and save costs, at the end stages of life.

CREATING AN EARLY RELEASE PROGRAM

Assuming clemency is, at best, a limited option for the early release of aging and ailing prisoners, can Florida create a broad elderly prisoner release program under existing state law to review and grant meritorious requests for release prior to 85 percent sentence completion? In order to be consistent with state law, the elderly release program would

24 "DOJ announces clemency overhaul, allows release for some after 10 years," Fox News, April 23, 2014.

25 "President Obama Could grant Clemency to Thousands of Non-Violent drug Offenders," Think Progress, April 21, 2014.

26 The only current avenue to reduce a sentence in Florida is through executive pardon and clemency. The Clemency Board does not typically grant nor revoke parole or probation, but there are examples of this power being used to reduce a sentence.

have to be specially tailored so that it does not offend the "*end, terminate or expire*" statutory language of mandating 85 percent completions.

The federal government provides an ideal road map on how to proceed, because the United States Federal Sentencing Guidelines enacted in 1987 also discontinued parole.[27] Like Florida, federal prisoners serve 85 percent of their sentences. The sentencing regime in the federal criminal justice system is very similar to Florida with one exception: the federal government has a Compassionate Release/Reduction in Sentence program which permits a prisoner to request early release in special circumstances which include advanced age, terminal medical conditions, other extreme and chronic physical limitations, and family hardships.[28]

A request for Compassionate Release goes to the Federal Bureau of Prisons (BOP), and if supported, the request is submitted it to a federal court, given unfettered discretion to approve the request.

In 2013, the BOP sought to reinvigorate the program with new guidelines for Compassionate Release/Reduction in Sentence, based on the detailed criticisms and recommendations from the DOJ IG.

These guidelines now permit Compassionate Release/Reduction in Sentence for the following:

- Prisoners with terminal medical conditions, defined as life expectancy of 18 months or less;
- Prisoners with a debilitative medical condition, which is an incurable progressive illness or injury which renders the prisoner confined to a hospital bed or unable to care for themselves;
- Prisoners 70 or older who have served 30 years of their sentence;
- Prisoners 65 or older who have served 10 years, or 75 percent of their sentence; and/or
- Prisoners 65 and older who have served 50 percent of their sentence and suffer from a deteriorating mental or physical health condition which diminishes the prisoners ability to function.

27 Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. 3582 and 4205

28 The Federal Bureau of Prisons Compassionate Release Program, U.S. Department of Justice Office of the Inspector General, April 2013

What should be the criteria for an elderly prisoner release program in Florida? The federal program outlined previously is a good place to start, but variables commonly included in state plans center on the following:

- ***Age***. This is the factor with the widest range of options. The age selected determines how large the eligible pool will be, and also determines how much risk will be accepted. Research studies and criminologists have consistently found that age is one of the most significant predictors of criminology. Ninety percent of those convicted of felons are under 50 at the time of admission to prison, and only 1.8 percent are 60 or older.[29]

  States have chosen to consider prisoners for early release as young as 45 in Louisiana; progressing to 55 (Alabama); 60 (Virginia, Wisconsin, Oklahoma); 65 (Colorado, Washington DC, Maryland, North Carolina, New Mexico); and 70 in the federal system.[30]

  Recidivism rates for elderly prisoners shed further light on age selection. FDOC did a 7-year study on recidivism by age groups using statistics from 2003-2010,[31] and found that the lowest recidivism rates occur among those aged 65 and older. The 50 to 64 year group also falls well below the average recidivism rates.

  Age profiles for prison admissions report similar age group distinctions. FDOC reports the 50-59 year group amounted to 8.6 percent of those admitted in 2012, 8.2 percent in 2011, and 7.8 percent in 2010. The number of prisoners aged 60 and over admitted to prison constituted 1.8 percent in 2012, 1.7 percent in 2011, and 1.5 percent in 2010.

- ***Medical Condition.*** The health criteria for early release consideration should be dependent on medical opinions regarding terminal illness, the progressive state of disease, treatment costs, chronic pain levels, and difficulty of care. Obviously, the graver the illness, the more cost to the taxpayer, and less danger to the public. Illness and physical disability can serve to incapacitate as readily as incarceration.

29 FDOC Annual Report 2012, page 31.

30 Federal: "Early Release for Federal Inmates: Fact Sheet", Nathan James, Congressional Research Service, February 3, 2014.

All other cited states: "It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release", Tina Chiu, Vera Institute of Justice, April 2010.

31 2011 Florida Prison Recidivism Report: Releases from 2003-2010. April 2012, Bureau of Research and Data Analysis.

- ***Offense Committed***. Some classes of crimes should be excluded from consideration for early release in the interest of public safety. Those who commit murder, sexual predators and rapists, offenses against children, and all other capital felonies should not be considered for early release in the interest of public safety.
- ***Time served.*** The amount of time served by the elderly prisoner should also be a consideration. Some states use a percentage ranging from 33–75 percent; others require 10–30 years.
- ***Risk Assessment***. Risk assessment is a very important consideration in all prison release programs. Age-based recidivism rates are instructive, but a prisoner's individual factors are equally germane. The specific facts of the offense committed, as well as the prisoner's record while incarcerated, family and community support, restitution, and all other relevant facts should be considered.
- ***Type of Decision-Making Forum***. The state of Florida has a Parole Commission, designed to ensure public safety through the post prison release process. The Commission is comprised of three Commissioners who are appointed to six year terms by the Governor, and confirmed by the Senate. Currently, the role of the Parole Commission is diminishing as prisoners sentences under the old philosophy disappear from the system.

Recommendations

The rising cost of health care for elderly prisoners is a national dilemma, creating budgetary headaches for the federal government and most states. Nowhere is this looming crisis more acute than in Florida. Florida's elderly prisoner population is now over 20,000, and on its way to 30,000 by 2018. By 2020, one out of every three prisoners in Florida will be elderly. This rate will be double the 16 percent national average, and impose huge and unsustainable fiscal burdens on Florida taxpayers.

Florida TaxWatch recommends that Florida implement the following measures designed to identify, assess, and manage the exploding aging prison population in Florida:

Report the Current Cost of Elderly Prison Health Care

Florida TaxWatch recommends that Florida collect and report the health care costs of the elderly prison population. Understanding the current costs for elderly heath care, the average cost per year to incarcerate an elderly prisoner, and the highest cost prisoners, are vital to the analysis and understanding of correction costs. Additionally, cost figures identifying current costs are necessary, so that cost projections can be determined and evaluated.

Report the Projected Growth of the Elderly Prison Population in Florida

The data is available for the state to project the growth in elderly prison populations. FDOC reports elderly statistics for the overall prison population, and the age groups of new prison admissions each year. The FDOC offender database also permits searches of those currently incarcerated by age. This provides sufficient data to project elderly prison population growth.

The state can use these projections, as it does to estimate future prison population totals, and make annual prison population projections for elderly prisoners. While prior year statistics show an elderly prison population which has grown from 5,605 in 2000, to 20,750 in 2014, the important information for decision-makers is if/when this growth will stop.

Consider clemency option for unique cases of elderly and ailing prisoners

Some cases cannot wait for FDOC and legislators to implement an early release program for elderly and infirm prisoners in Florida. As an example, there are currently 27 prisoners over 80 years of age who have been incarcerated for decades, and have release dates in the next 5 years. Three of these prisoners are in their nineties. They are feeble and harmless to the general public. There are also prisoners with life-threatening diseases in the end stages of life.

These prisoners should be considered for release, and clemency is the only way this can be done in adequate time to allow a more compassionate death outside of prison walls.

Implement an Elderly Prisoner Release Program

The Florida Legislature should reexamine the fundamental purposes and goals of prison and sentencing, which are to punish, incapacitate, deter future crimes, and rehabilitate. Prisons are not intended to be senior citizen retirement communities or hospice centers for prisoners with terminal diseases. Old age, life-threatening medical conditions, loss of physical mobility, and degradation of sensory and memory recall can incapacitate as surely and effectively as prison cells, watchtowers, and barbed wire.

In order to stop runaway spending on health care for elderly prisoners, a program should be created in Florida to review aging and ill prisoners for release to community medical clinics and hospices. The program can be modeled on the federal Compassionate Release/ Reduction in Sentence program, and other geriatric release programs implemented by sister states. Criteria would likely be based on age, offense, medical status, prison record, public safety assessment and humanitarian factors, but should not be automatic based on any of those factors.

The recommendations made by the U.S. DOJ IG report after thorough review of the federal Compassionate Release/Reduction in Sentence program in 2013 are germane and should be carefully analyzed. The DOJ IG report found the process so encumbered with review layers, and the criteria for eligibility so tightly structured and interpreted, that the program was mired in red tape and ineffective.

Florida should look to this program as a model, and borrow the best practices from state programs discussed in this study, when creating appropriate criteria for elderly prisoner early release.

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Dan McCarthy is a Miami native and a graduate of the United States Naval Academy. He also has a law degree from Duke University and an LLM from George Washington. Before joining TaxWatch, Dan spent three decades as a naval officer where he served as a legal advisor to the Secretary of the Navy and was in command of all Naval trial offices in the Southeast and Caribbean. He has also worked at the law firm of Holland & Knight, served as the Director for Military and Veterans Affairs for the City of Jacksonville, was the Chief Assistant State Attorney for the 4th Circuit, and was a Director at Wounded Warrior Project.

ABOUT FLORIDA TAXWATCH

As an independent, nonpartisan, nonprofit taxpayer research institute and government watchdog, it is the mission of Florida TaxWatch to provide the citizens of Florida and public officials with high quality, independent research and analysis of issues related to state and local government taxation, expenditures, policies, and programs. Florida TaxWatch works to improve the productivity and accountability of Florida government. Its research recommends productivity enhancements and explains the statewide impact of fiscal and economic policies and practices on citizens and businesses.

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The Center for Smart Justice is centered on the belief that public safety is paramount, and because of the magnitude of this responsibility, there truly is no room for inefficiency. The Center's research focuses on evidence-based reforms to Florida's criminal and juvenile justice systems that ensure less crime, fewer victims, and no wasted tax dollars.

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This independent *Report* was made possible by the generous financial support of Florida TaxWatch donors.

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CourtSmart Tag Report

Room: LL 37 **Case:** **Type:**
Caption: Senate Criminal Justice **Judge:**

Started: 1/20/2015 3:34:19 PM
Ends: 1/20/2015 4:58:23 PM **Length: 01:24:05**

3:34:21 PM Roll Called by CAA
3:37:19 PM Presentation by OPPAGA - Matthew Moncrief , Sr. Leg. Analyst
3:43:31 PM Questions/Discussion by Senators
3:48:40 PM Presentation by CMA - Jane Holmes, Executive Director
3:58:54 PM Questions/Discussion by Senators
4:13:18 PM Jane Holmes with CMA (continue presentation)
4:15:40 PM Presentation by Department of Corrections- Julie Jones, Secretary of DOC
4:23:21 PM Dr. Dean Aufderheide, Director of Mental Health Services
4:27:18 PM Questions/Discussion by Senators
4:28:21 PM Julie Jones - Secretary of DOC (presentation continued)
4:57:13 PM Senator Bradley motion to adjourn