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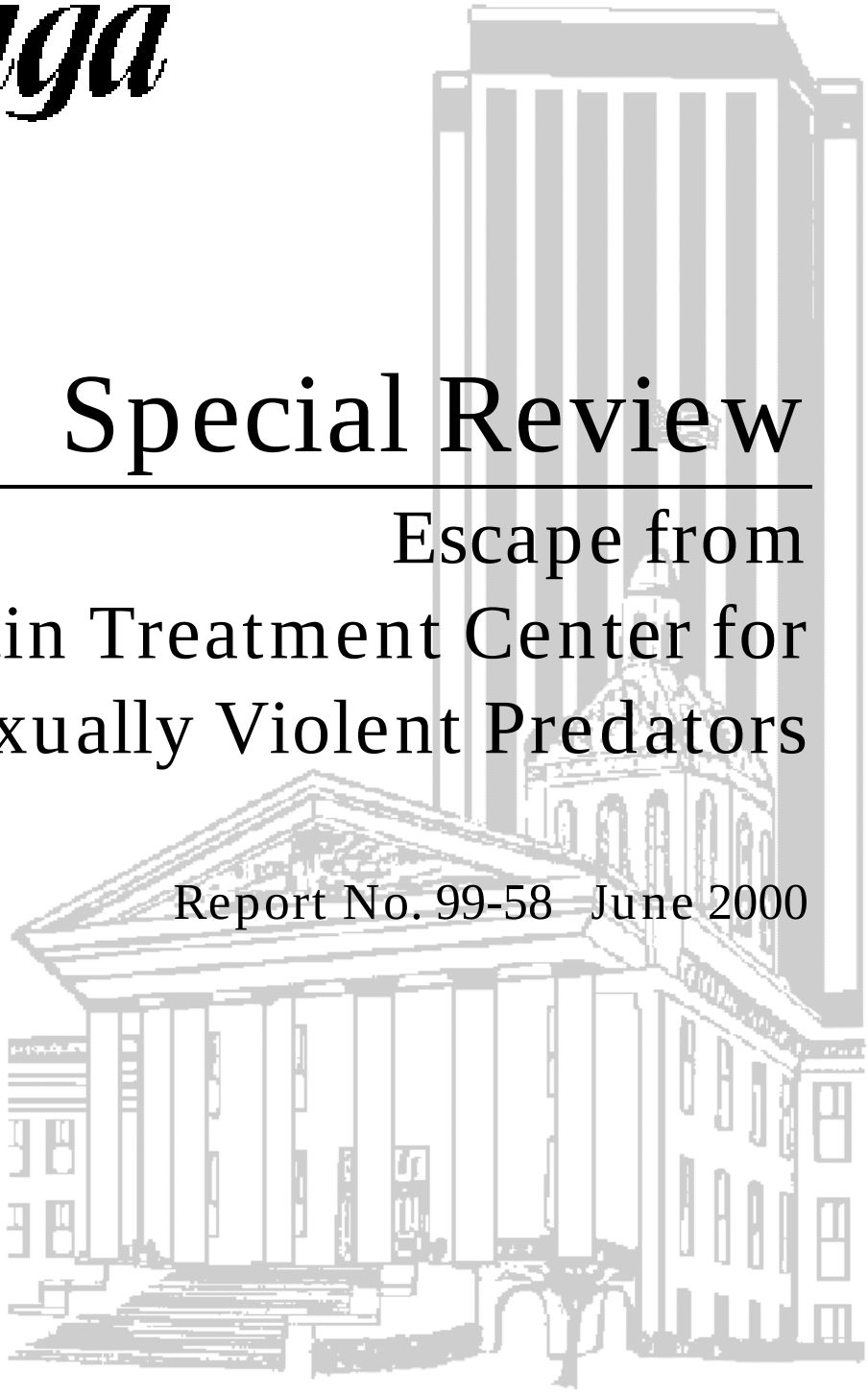

# Special Review

## Escape from Martin Treatment Center for Sexually Violent Predators

Report No. 99-58 June 2000

*Office of Program Policy Analysis and Government Accountability*

*an office of the Florida Legislature*

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*The Florida Monitor:* ***http://www.oppaga.state.fl.us/***

Project conducted by Richard Dolan (850/487-0872), Marti Harkness, and Kathy McGuire

# The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

**John W. Turcotte, Director**

June 2000

The President of the Senate,
the Speaker of the House of Representatives,
and the Joint Legislative Auditing Committee

The Joint Legislative Auditing Committee of the Florida Legislature directed that a review be made of the escape from the Martin Treatment Center for Sexually Violent Predators. The results of this review are presented to you in this report. This review was conducted by Richard Dolan, Marti Harkness, and Kathy McGuire.

We wish to express our appreciation to the staff of the Department of Children and Families, the Department of Corrections, the Martin County Sheriff's Office, and Liberty Behavioral Heath Care, Inc., for their assistance.

Sincerely,

John W. Turcotte
Director

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# Table of Contents

# *Special Review of the Escape from Martin Treatment Center*

## *General Conclusions*

This report provides information to the Legislature about security at the Martin Treatment Center for Sexually Violent Predators. Predators have been convicted of a sexually violent offense and are considered likely to engage in future violence. To treat these offenders, the Legislature created a civil commitment process. The Department of Children and Families is responsible for the program, which is housed in Martin County. The department contracts with Liberty Behavioral Health Care, Inc., to operate the program and the Department of Corrections to provide security.

On June 5, 2000, at 1 p.m., one resident scaled an interior fence and boarded a helicopter that flew in from the south and landed on the compound inside the perimeter fences. The helicopter cleared the perimeter fences and crashed about 100 yards away. The pilot and the escapee fled and were apprehended 26 hours later.

Three factors contributed to the escape. First, too few staff; at the time of the escape, only one Liberty therapeutic aide was in the yard to supervise 40 residents. Second, Liberty had removed the razor wire from the top of the recreation yard fence, making it easy to scale. And finally, correctional officers guarding the perimeter were not armed.

To deter future escapes, Liberty is developing specific staff-to-resident supervision ratios and is considering increasing the number of aides per shift. The Department of Corrections has armed its perimeter officers for self-defense, installed a walk-through metal detector at the front gate, and added fencing.

The Sexually Violent Predator Treatment Program is scheduled to begin moving to the DeSoto Correctional Institution in November 2000. Given this imminent relocation, recommendations for major capital improvements to Martin Treatment Center's infrastructure would not appear to be cost-effective.

We recommend that the department ensure that renovations to DeSoto support both the facility's treatment mission and essential security. While the program remains at Martin, we recommend that Liberty immediately increase outdoor staff supervision of residents and replace the razor wire on the recreation fence. To allow correctional officers to better protect themselves, we concur with the Department of Correction's decision to arm perimeter officers for self-defense.

# *Special Review of the Escape from Martin Treatment Center for Sexually Violent Predators*

## *Purpose*

This report provides information to the Legislature about security at the Martin Treatment Center for Sexually Violent Predators. The report

- describes the June 5, 2000, escape from the treatment center,
- analyzes factors related to security that contributed to the escape, and
- identifies policy options for deterring future escapes.

OPPAGA will issue a second report in September 2000 assessing the performance of the contractor the state has hired to provide treatment to sexually violent predators at the Martin facility, examining the Department of Children and Families contract monitoring practices, and providing recommendations for improvements as appropriate.

## *Methodology*

To prepare this report, we inspected prison and treatment facilities, conducted interviews and reviewed event logs, and assessed policy and procedures. We obtained information from staff of the Department of Corrections, Liberty Behavioral Management, Inc., the Martin County Sheriff ŝ Office, and the Department of Children and Families.

We made several trips to the Martin Treatment Center, including an unannounced night visit to review final count and night lockdown procedures. We also inspected the DeSoto Correctional Institution and spoke to the warden about renovations that are scheduled so that the treatment program can be relocated from Martin to DeSoto.

We spoke to all Department of Corrections officers and supervisors that were on duty at the time of the escape, both inside the Martin Treatment Center and on the perimeter, and reviewed their written statements of the incident. We also interviewed other correctional officers during our

trips to the treatment facility. We spoke to the warden and assistant warden of nearby Martin Correctional Institution about corrections policies and procedures relating to helicopter escapes, use of force, visitation rules, and rules for the correctional officers at the prison and at Martin Treatment Center. We also met with Department of Corrections central office staff in charge of security to examine possible methods to deter future escapes.

We spoke to Liberty staff that were on duty at the time of the escape and reviewed all staff accounts of their actions relating to the escape. We also interviewed other managers, treatment staff, and therapeutic aides, and some residents during our visits to the center, as well as reviewing policies and procedures and reports related to the incident.

We interviewed command staff of the Martin County Sheriff's Office about their role in capturing the individuals who had fled in the helicopter and reviewed their radio logs and investigative reports of events relating to the escape.

We met with Department of Children and Families Sexually Violent Predator Program staff to assess their response to the escape and examine efforts to prevent future escapes. We also reviewed with them the judicial principles and rulings relating to confinement and treatment of sexually violent predators.

# Background

## The Jimmy Ryce Act

As defined by statute, sexually violent predators are persons who have been convicted of a sexually violent offense and have a mental abnormality or personality disorder that makes them likely to engage in future acts of sexual violence if not confined in a secure facility for long-term control, care, and treatment.

***The act is an involuntary civil commitment process***

To address the treatment needs of these offenders, the Florida Legislature passed the Involuntary Civil Commitment of Sexually Violent Predators Act, also known as the Jimmy Ryce Act, which became effective

January 1, 1999.[1] The Ryce Act creates a civil commitment process for sexually violent predators that is similar to the Baker Act procedures to involuntarily commit and treat mentally ill persons.

The Jimmy Ryce Act directs the Department of Children and Families to implement the Sexually Violent Predator Program.[2] The department is responsible for the assessment, custody, and treatment of individuals detained or committed pursuant to the act.[3] Detainees have completed their criminal sentences and are awaiting processing by the courts to determine if they will be committed to the program.[4] Offenders that are committed by the court remain in the program until it is determined that they are no longer a threat to public safety. The act directs that their status be reviewed annually.

The Legislature modeled Florida's violent sexual predator program on one operating in Kansas because it had recently been upheld by the United States Supreme Court.[5] The Kansas program had been legally challenged as double jeopardy because inmates who had already served their criminal sentences were subsequently involuntarily detained for treatment. Among the issues raised was whether individuals were being held for further punishment or were actually being treated. The United States Supreme Court held that if a program provides true treatment in a non-correctional, non-punitive environment, it is constitutional.

This decision was instrumental in Florida policy because it made clear that the program must provide viable treatment while at the same time assuring adequate public safety. This is why the program was placed in the Department of Children and Families, the state mental health agency. The challenge of Florida's Sexually Violent Predator Treatment Program is to assure that treatment is provided in a manner that makes it clear that residents are not in prison, even though they are in a secured environment.

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[1] Sections 394.910 through 394.931, *F.S.*

[2] The Mental Health Program Office administers the Sexually Violent Predator Program. In Fiscal Year 1999-2000, the Legislature appropriated $17.8 million to the program.

[3] We reviewed the assessment process in OPPAGA Report No. 99-36, *The Sexually Violent Predator Program's Assessment Process Continues to Evolve*, issued February 2000.

[4] Criminal sentences are served under the supervision of the Department of Corrections or the Department of Juvenile Justice. Persons found not guilty by reason of insanity have been committed to the Department of Children and Families for treatment and have been released by hearing.

[5] Kansas v. Hendricks, 521 U.S. 346 (1997).

# Martin Treatment Center for Sexually Violent Predators

***Most residents are waiting for their day in court***

The department houses both detainees and committed offenders at the Martin Treatment Center for Sexually Violent Predators. [6] Because this is a civil commitment and treatment process, participants are referred to as residents. As of June 28, 2000, 106 residents were housed at the Martin center. Of these, the court has committed 11 as sexually violent predators and 95 are still awaiting judicial determination of their status.

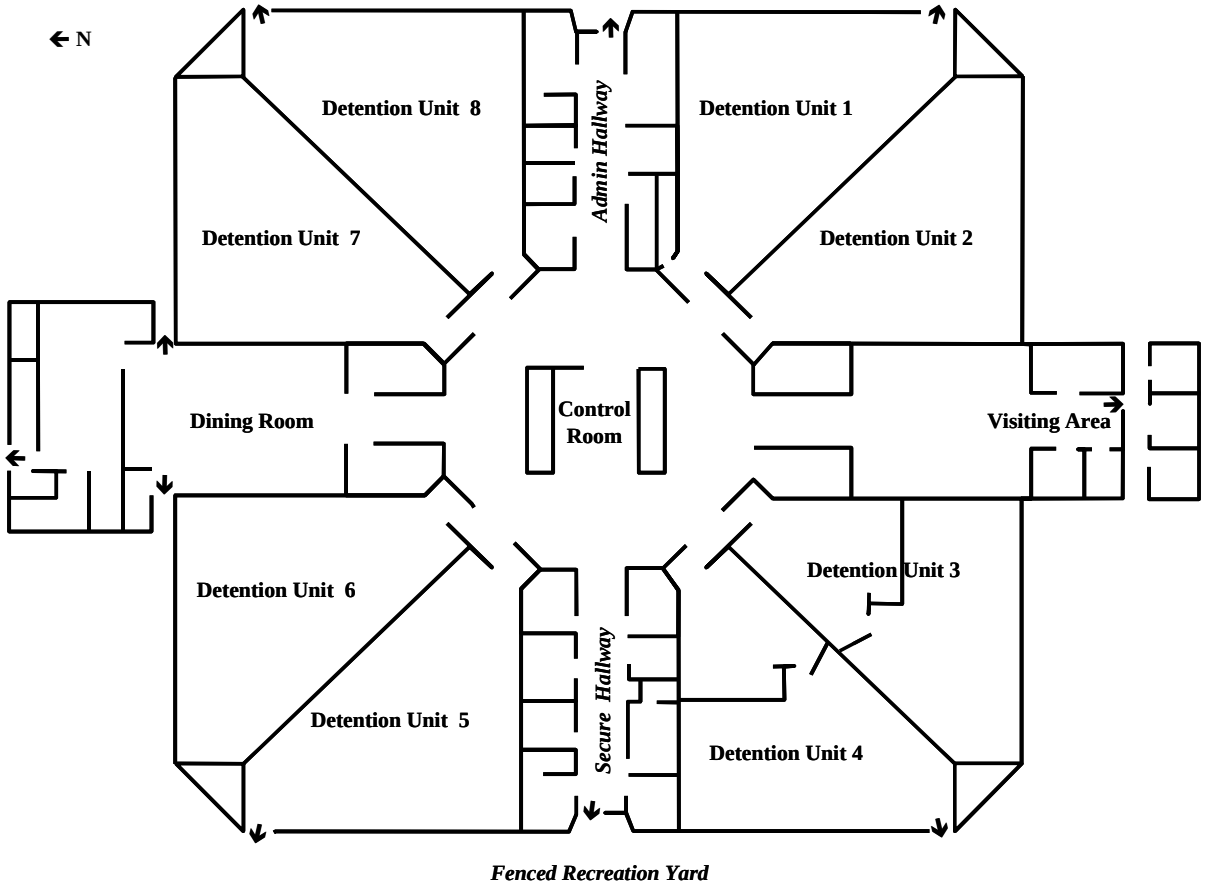
The Martin Treatment Center was originally a jail built in 1984 by Martin County on land leased from the state. The county built another facility on its own land closer to the county courthouse. In 1990, the county turned the facility over to the Department of Corrections, which also operates the Martin Correctional Institution, a separate compound located approximately 200-300 yards north of the center. The department used the facility to house a drug treatment program until 1998. In 1999, the facility was turned over to the Department of Children and Families to house sexually violent predators.

***The program is housed in a former jail***

Martin Treatment Center is configured as a correctional facility. (See Exhibit 1.) It is a square building that contains eight detention units within four wards. Each unit houses 12 to 18 residents in an open dormitory configuration. The building also includes two single-person cells that can be used to separate residents from the rest of the group. A control room is located in the center of the wards. The facility contains a dining room, administrative offices, and a visiting area that serves as a group treatment room. Additional administrative offices are located in a trailer on the side of the compound. An exit on the west end of the facility leads to a recreation area comprising a yard, a volleyball court, a basketball court, and a weightlifting enclosure.

[6] Detainees who do not agree to participate in the treatment program are sent to South Bay Correctional Institution. As of June 28, 2000, 92 detainees were housed at South Bay. In addition, one committed resident is being housed at South Bay until he can be medically stabilized.

### *Exhibit 1: Martin Is Configured Like a Jail*




Source: Martin Treatment Center.

# *Security at Martin Treatment Center*

The Department of Children and Families operates the Martin Treatment Center through two contracts. The department hired Liberty Behavioral Health Care, Inc., to operate the program and provide treatment to both detained and committed residents. Liberty is responsible for managing the residents throughout the compound. The department contracted with the Department of Corrections to provide other aspects of security, including controlling facility ingress and egress, operating electronically controlled internal and external doors, and providing perimeter security. Department of Corrections staff operate from the control room in the center of the facility.

To gain access to the facility, a visitor must be admitted through three secure exterior gates. First, a Department of Corrections officer radios the control room staff to unlock the main gate. When the visitor passes the first gate and is between the two gates, the officer uses a hand-held electronic metal detector to search the visitor for unauthorized items. After the search, the gate officer provides the visitor a Department of Corrections identification tag and uses a key to open the second gate. After closing the second gate, the officer radios the control room staff to unlock the final gate leading to the administration door of the facility.

***Liberty and Department of Corrections both provide security***

Once inside the facility, a visitor must be approved or escorted by a Liberty staff member. Ward ingress and egress is through a pair of electronically controlled doors operated by correctional officers in the control room. Liberty staff dictate the movement and management of the residents inside the compound. That is, Liberty staff make the decisions to open and close all doors to the main wards and to the recreation and administrative offices trailer area. Liberty staff have their own radio system, independent of the Department of Corrections radio system, to call the control room and ask that specific doors be opened or closed. Correctional officers in the control room therefore operate two sets of radios - Liberty radios to respond to requests to open and close internal doors and Department of Corrections radios to operate doors at the front gate.

Martin Treatment Center compound is surrounded by a 12-foot perimeter fence, 30 feet of open space, and a second 12-foot perimeter fence. Within the compound the recreation area is surrounded by an additional fence with barbed wire. The perimeter fencing is standard correctional fencing protected with razor wire, barbed wire, and microphonic and microwave devices that detect when something touches the inside portion of the pair of fences or passes through the area between the two perimeter fences. The Department of Corrections also provides three officers outside the compound.[7] Two officers are positioned in parked vehicles and the third drives a vehicle around the perimeter on a random basis.

At the onset of the program, the Department of Children and Families asked the Department of Corrections to specify what needed to be done to make Martin Treatment Center secure, and included the work list as part of their contract. These repairs and renovations included adding

[7] The perimeter correctional officers have been armed with less than lethal weapons, such as pepper spray. They will be armed for self-defense in July 2000.

improvements such as fences, razor wire, microwave and microphonic systems, recreation yard lighting, and perimeter security vehicles. [8] Some but not all of the agreed-upon improvements had been made by the time of the escape; for example, the walk-through metal detector had not been installed, the gravel perimeter road had not been paved, and the additional lighting had not been installed. However, these uncompleted work projects did not contribute to the June 5 escape.

The revisions planned for Martin Treatment Center made security at the center more stringent than the state's other mental health facilities and similar to correctional institutions with one exception: the facility does not have correctional officers armed with lethal weapons because the residents are civilly and not criminally detained. Like state correctional facilities, Martin does not have helicopter-deterrent hardware.

# Escape from Martin Treatment Center

## Description of the escape

Prior to his escape, resident Steven Whitsett was visited by long-time friend Clifford Burkhart. [9] Like other residents, Whitsett was allowed to have visitors. Burkhart visited Whitsett at the treatment center on 10 occasions between February 6, 2000, and June 4, 2000. Two of these were special visits made in February prior to Burkhart being approved as a regular visitor and being placed on Whitsett's approved visitor list. The first special visit occurred on February 6, 2000. However, when Burkhart arrived that day at the facility, the visit was cancelled due to some renovations being made. Because this visit was cancelled, he was allowed to return to see Whitsett on February 15, 2000. Both visits were approved by Robert Lay, a Liberty employee who was Whitsett's case manager. Burkhart's final visit was made June 4, 2000, the day before the escape.

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[8] Microwave systems use radio waves to set up a beam between a transmitter and a receiver. Once the beam is broken, an alarm in the control room indicates where the beam has been broken. Microphonic systems consist of cables strung with sensors on the fence to pick up vibrations that indicate if someone is trying to climb or cut the fence. The control room is also alerted when this system is activated.

[9] Whitsett was a detainee not yet committed to the program by the court. His criminal history included a March 1994 plea of no contest to sexual solicitation of a 16-year old and he had been sentenced on February 2, 1995, to 8 years in prison and 15 years probation for sexual battery on a child by a person in custodial authority and for lewd, lascivious or indecent assault on a child.

On June 5, 2000, at approximately 1 p.m., correctional officers patrolling the perimeter of the treatment center and Liberty staff reported near simultaneous observations of a helicopter approaching from south of the facility. The helicopter was later identified as a two-person, 1993 "Robinson 22." At the time, approximately 40 residents were in the recreation yard of the compound monitored by one Liberty therapeutic aide, Larry Barriner. He was providing oversight of the gate between the center and the administrative office trailer and supervising the residents in the recreation yard. Tyrone Lee and D.R. Mosley, two other Liberty aides that had also been supervising the recreation yard, had just escorted other residents into the facility.

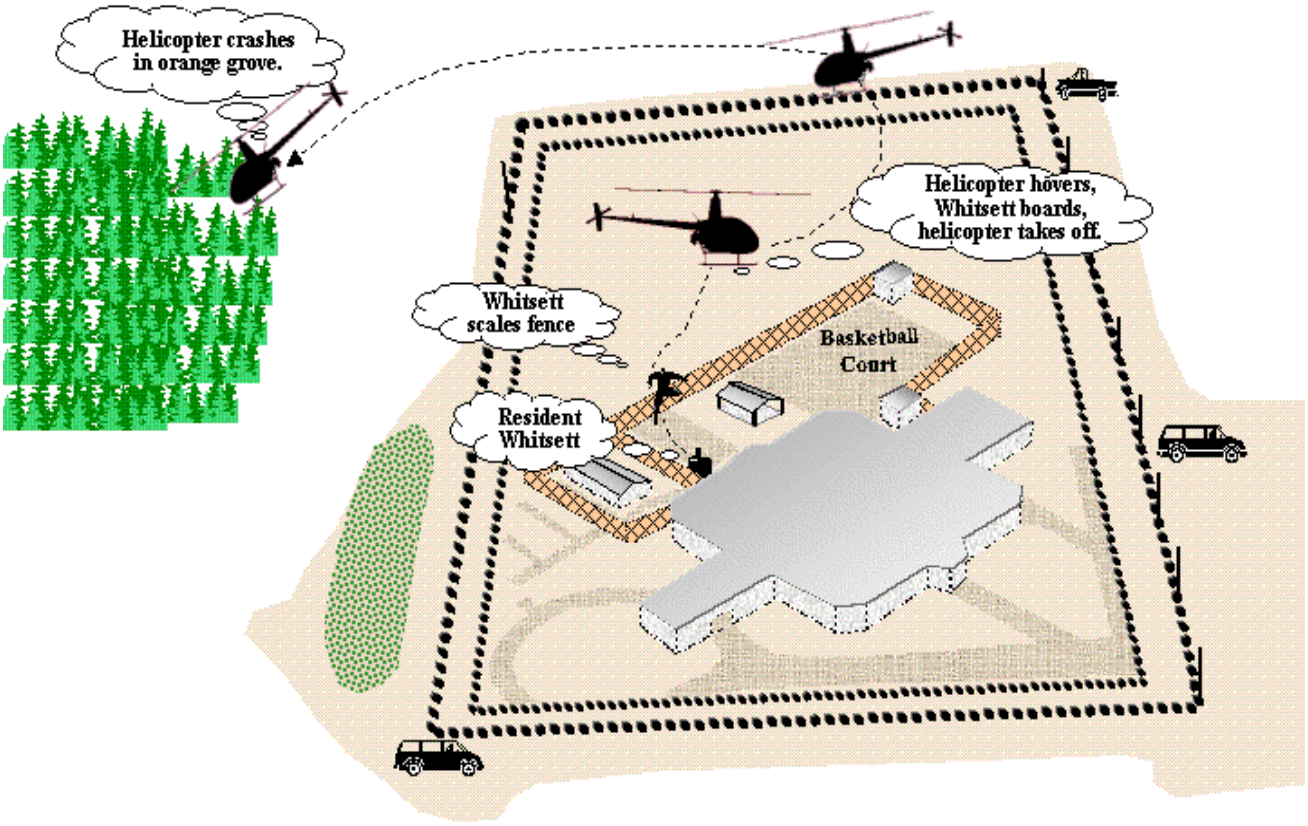
***The escape took only a few minutes***

Within one to four minutes of the initial reports, the helicopter, piloted by an individual later identified as Clifford Burkhart, flew to a large open area between the secure outer perimeter and interior fence. [10] (See Exhibit 2.) In the meantime, resident Stephen Whitsett climbed over the recreation area fence and ran to the open area of the compound inside the perimeter fences. The helicopter hovered close enough to the ground to allow Whitsett to board. According to most accounts, the helicopter tilted and sustained damage as Whitsett boarded it. One of the landing skids broke, pitching the helicopter sideways, which forced the rotor to hit the ground. As a result of the damage, the helicopter was only able to gain enough altitude to clear the perimeter fences. Within seconds the helicopter crashed about 100 yards south of the perimeter fence, on the other side of a canal.

After the crash, Whitsett and Burkhart immediately fled into the orange groves. Although the correctional officers quickly converged on the near side of the canal from the crash site, they did not see the two men flee. When officers searched the wrecked helicopter, they found two empty gun holsters and acted on the belief that Whitsett and Burkhart were armed.

[10] Burkhart had no previous criminal history.

## *Exhibit 2: Helicopter Flight Was Short-Lived*




Source: Prepared by OPPAGA based on Martin Treatment Center internal incident reports.

Staff of many agencies, including the Department of Corrections, Martin County Sheriff's Office and other local law enforcement agencies, the Department of Law Enforcement, the Highway Patrol, the Marine Patrol, and the Federal Aviation Authority joined efforts to capture Whitsett and Burkhart. They determined that Burkhart had been taking flying lessons from a company in Fort Lauderdale and used the helicopter for the escape during a solo practice flight. Law enforcement officers also found a van that appeared to be a get-away vehicle, and staked it out in case the men came for it. In the van, officers found a key to a motel room in Okeechobee and train tickets to New York.

Trackers, canine units, and helicopters with infrared lights searched the vicinity. Twenty-six hours from the time of the escape, a Martin County Sheriff's deputy spotted Whitsett and Burkhart from a search helicopter. The two men were in a canal, in shoulder-deep water, four miles east of

the treatment facility near a Stuart subdivision called Cobblestone, which is just east of Interstate 95 at State Road 714. The deputy exited the hovering helicopter, confronted the men, and ordered them from the water. When they refused, the deputy fired two warning shots. The men then complied with the deputy's orders. The men were armed with two nine-millimeter handguns and 28 rounds of ammunition.

Liberty's post-escape investigation revealed that Whitsett had prepared for his escape. On May 28, 2000, Whitsett had sent several personal items home. However, staff had not considered this unusual because many residents had sent home personal possessions because property limitations were being more stringently enforced. At the time of the escape, Whitsett's footlocker was found empty; apparently he had given his clothing and other items to other residents. Whitsett had told them that he had a court date on June 5 or 6, 2000, and that his attorney had assured him that he would be getting released and not returning to the treatment center.

On June 7, 2000, Circuit Judge David Harper denied the men bail. State Attorney Robert Belanger has charged both men with armed escape while in custody, which could result in up to 30 years in prison. Whitsett is also charged with possession of a firearm by a convicted felon. Burkhart is also charged with reckless operation of an aircraft.

See Appendix B for Liberty's description of events surrounding the escape.

## Security factors that contributed to the escape

Three factors pertaining to security contributed to the escape on June 5, 2000.

- Liberty staff were unable to prevent Whitsett from fleeing the recreation yard.
- Liberty had removed the razor wire from the top of the recreation fence.
- Perimeter correctional officers were unable to stop the helicopter.

## Recreation area staffing

***Too few staff in the yard***

The one Liberty staff member who was in the recreation area at the time of the escape did not see Whitsett leave and therefore was unable to deter him from scaling the interior fence and running to and boarding the helicopter. Liberty has no policy for staff-to-resident supervision ratios, or for the minimum number of staff to be on the recreation yard. According to Robert Briody, Ph.D., director of the Martin Treatment Center, a normal staffing pattern for supervising the recreation yard is three therapeutic aides. On the afternoon of the escape, approximately 55 residents had been out in the recreation yard. Three therapeutic aides (Tyrone Lee, D.R. Mosley, and Larry Barriner) had been monitoring the residents, one of whom, Barriner, was also monitoring the side gate leading to the Liberty program staff trailer to let staff in and out and to make sure that residents did not slip through the gate to assault staff in the trailer. The other two aides had been monitoring activity in the weightlifting compound and around the basketball court.

Shortly before 1 p.m., two of the therapeutic aides, Mosley and Lee, re-entered the facility through the west wing with 13-15 residents. The therapeutic aides were en route to a staff training class, and two other aides were being assigned to the recreation yard. This left only one aide to provide gate control for the Liberty program staff and monitor the remaining 40 residents in the recreation area. Although Barriner remembers Whitsett being in the recreation yard at the time of the escape, he did not see Whitsett run to the internal fence and climb it. The aide explained that it was difficult to sufficiently monitor 40 residents as well as act as gatekeeper. No staff person witnessed how Whitsett was able to get past the internal fence and run to the helicopter in the open area inside the perimeter fences. If additional aides had been on the recreation field, they might have been able to restrain Whitsett from scaling the fence or pulled him off the fence.

## Removal of razor wire from the recreation fence

***Fence easy to scale***

The lack of razor wire on the recreation yard security fence facilitated Whitsett's escape. As shown in Exhibit 2, a security fence surrounds the recreation yard on the west end of the facility. Until recently, the fence had both v-shaped barbed wire and razor wire on the top of it. In May

2000, Robert Briody, Martin Treatment Center's director, asked the Department of Corrections to remove the razor wire from most of the internal fence because the razor wire was in close proximity to the residents 'volleyball court and was damaging the volleyballs.

Dave Harris, assistant warden, and Chester Lambdin, warden at the Department of Correction's Martin Correctional Institution, acted on the request and removed the wire. They did not feel they had control over this issue because it was an internal, rather than a perimeter security matter. The razor wire was removed without the knowledge or approval of the Department of Children and Families program director. Although the barbed wire was left up, without the razor wire the security of the internal fence was compromised, allowing Whitsett to scale the fence without fear of severe injury and flee to the large open area within the perimeter fences. However, if the razor wire had not been removed, it is possible that Whitsett's accomplice might have tried to land the helicopter on the basketball court, which including the open space around it, is 104 by 123 feet. According to Samuel Pirozzi Jr., a Liberty therapeutic community manager that interviewed Whitsett following his capture, landing on the basketball court was their original plan.

## Correctional officers were unable to stop the helicopter

Because residents are civilly and not criminally incarcerated, correctional officers were only authorized to carry non-lethal devices to defend themselves, such as pepper spray and stun guns. Even if staff had been armed, it is unlikely that the officers would have fired on the helicopter. According to Stan Czerniak, director of institutions, Department of Corrections, officers could choose not to fire to protect staff, residents, and citizens from stray bullets and avoid triggering an explosion of the aircraft.

# *How can further escapes be deterred?*

Greg Venz, the director of the Department of Children and Families' Sexually Violent Predator Program, is still developing a report on how the department will deter future escapes. The program's contractors, the Department of Corrections and Liberty Behavioral Health Care, Inc., prepared reports describing the incident and offering proposed

recommendations for improving security at Martin Treatment Center. (See Appendices A and B.) The differences in their solutions reflect the differing missions of the two entities: the Department of Corrections emphasizes security, whereas Liberty focuses on treatment. An example of where the two approaches differ is on appropriate resident dress. The Department of Corrections proposes that residents wear only uniforms so that they are easily distinguishable from staff and visitors. According to Liberty, resident uniforms are not needed due to the other security provisions and would unnecessarily make the civil treatment program more like a prison.

To enhance security following the escape, the Department of Corrections has completed the microwave detection system on the perimeter pair of fences, installed a walk-through metal detector at the front gate, and completed additional fencing to restrict movement within the compound. The department has also decided to allow perimeter officers to carry firearms for self-defense.

Liberty is revising and updating its procedures manual to adopt specific staff-to-resident supervision ratios and is considering increasing the number of therapeutic aides per shift.

The Department of Children and Families should review its contractor's recommendations, determine the most appropriate response, and ensure that timely responses are made.

***Program moving to new location***

The Martin Treatment Program is scheduled to begin moving to another facility in four months. Through budget proviso language, the 2000 Legislature made available $6 million to the Department of Children and Families to contract with the Department of Corrections to renovate some buildings at the DeSoto Correctional Institution to replace the Martin facility as the sexually violent predator treatment center. Moving the program to DeSoto will consolidate residents from Martin Treatment Center and South Bay Correctional Institution to one location and provide more appropriate space for detention and treatment. Renovations are expected to begin in July 2000, and the director of the Department of Children and Families' Sexually Violent Predator Program anticipates relocating up to 208 residents by November 2000, and competing the move no later than June 30, 2001.

The DeSoto facility will enhance both treatment and security because it includes multiple buildings on a large compound that will provide

adequate space for treatment and better protection for security staff. [11] Plans call for three dormitories; two will be open-bay dorms with five-foot tall partitions creating individual spaces that contain a bed, desk, and storage space, and one dorm will be a single-cell lock-down unit of 120 cells. Residents not cooperating with treatment will be housed in the lock-down unit. The dorms will be air-conditioned and have day rooms for treatment. Three other buildings will be used for administration/support and education. There is also a visitor pavilion. There are many buildings in this 14-acre compound, but the others will not be used initially. Ingress and egress to the facility is through secured gates with walk-through metal detectors and a control room on the perimeter monitors security.

Because this facility was formerly a correctional institution, the large fenced yard is like those at state prisons. However, the fencing standards have changed since DeSoto was built, so the perimeter fencing needs to be increased and a microwave system installed. Also, there are currently no guard towers on the perimeter.

# OPPAGA Recommendations

Given the imminent relocation of the Sexually Violent Predator Treatment Program from Martin to DeSoto, the security improvements made since the escape appear to be reasonable and further improvements to Martin's infrastructure would not appear to be cost-effective.

The state has not invested in apparatus such as poles and cables, and other anti-helicopter hardware proposed in the Department of Corrections and Liberty reports, for other mental health or prison institutions. Decisions about whether to add them at the sexually violent predator treatment program should be made in the larger context of the Department of Corrections statewide mission. If the department does determine that such measures are appropriate, an assessment of the cost of implementing such a strategy will need to be made.

To enhance security of the new Sexually Violent Predator Treatment Center, we recommend that the department ensure that renovations of the DeSoto physical plant support both the facility's treatment mission

[11] For example, correctional officers at the facility entrance will be in a protected control room rather than in an open shed. In addition, officers will no longer need to be responsible for operating internal doors as they are at Martin. This will allow them to focus on external threats to security.

and essential security, such as modification of perimeter fencing to meet current correctional standards.

While the program remains at Martin, we recommend that Liberty immediately adopt procedures to increase staff supervision of residents in the recreation area. So that these staff are not unnecessarily distracted, we further recommend that Liberty eliminate access to the program staff trailer through the recreation yard. The fencing surrounding the program staff trailer should be reconfigured to allow staff to walk around the south side of the facility and enter via the administration wing. This would eliminate the need for monitoring the security of the gate in the recreation yard and make it a completely secure area, thereby freeing Liberty staff to spend more time supervising the residents.

To allow correctional officers to better protect themselves and fulfill their mission, we concur with the Department of Correction's decision to allow perimeter officers to carry weapons. The department should also immediately replace the razor wire that was removed from the interior fence surrounding the recreation yard.

We will address treatment and contract monitoring issues, and make appropriate related recommendations, in our second report on Martin Treatment Center for Sexually Violent Predators, to be issued in September 2000.

## *Appendix A*

# *Summary Report by the Department of Corrections of Events Occurring on June 6 and 7, 2000, at the Jimmy Ryce Treatment Center*

**STATE OF FLORIDA**
**DEPARTMENT OF CORRECTIONS**

**OFFICE OF INSTITUTIONS**
**BUREAU OF SECURITY OPERATIONS**

**MEMO TO:** **Michael D. Wolfe, Deputy Secretary**

**FROM:** **Thomas A. Crews**

**DATE:** **June 13, 2000**

**RE:** **Jimmy Ryce Treatment Center**

Per your request, I have prepared a summary report of the modified security audit conducted at the Jimmy Ryce Treatment Center, June 6 – 7, 2000. I have also included information that was requested as a result of our meeting with the Governor's staff and members of Children and Family Services.

If you need additional information, please advise.

/s/
Thomas A. Crews, M.Ed., C.P.M.
Correctional Programs Administrator
Bureau of Security Operations

Cc; Stan W. Czerniak, Director, Office of Institutions
Jerry L. Vaughan, Deputy Director, Office of Institutions
James R. Upchurch, Chief, Bureau of Security Operations

**STATE OF FLORIDA**
**DEPARTMENT OF CORRECTIONS**

**OFFICE OF INSTITUTIONS**
**BUREAU OF SECURITY OPERATIONS**

**MEMO TO:** **Stan W. Czerniak, Director**

**FROM:** **Thomas A. Crews**

**DATE:** **June 8, 2000**

**RE:** **Martin Unit Treatment Center – Jimmy Ryce Center**

Per your instructions, Stephen Y. Roberts, Calvin W. Hemphill, and I traveled to the Jimmy Ryce facility at Martin Correctional Institution for the purpose of looking at security issues that may have led to the recent helicopter escape from the facility, as well as, to look at ways to possibly prevent this type of incident from occurring again.

We arrived at the facility at approximately 8:00pm on the evening of June 6, 2000, and met with Assistant Wardens Ray Snell, David Harris and Brian Welch. We toured the inside of the facility concentrating on control room activities, resident movement, staff interaction with the resident population, and the overall operation of the facility from a security perspective.

We then toured the outside of the facility and walked the compound and portions of the perimeter looking at lighting and coverage provided by the Department of Corrections staff working the gates and perimeter.

On Wednesday, June 7, 2000, we returned to the facility and repeated the same process to provide us with a look at the daytime activities and operations. We met with Dr. Robert Briody who is the Executive Director of the facility and members of his staff. We toured the facility both inside and on the compound, where Dr. Briody discussed some of the concerns he had with the physical plant and with the relationship between the Department of Children and Family Services, the Department of Corrections and the contract provider staff of Liberty Behavioral Services.

The attached pages are highlights of our modified security audit of the facility. We have tried to outline the issues as we saw them and provided some recommendations for your review and consideration.
We are prepared to discuss these issues and recommendations with you at your convenience. If we can of further assistance in this matter, contact us as needed.
/s/
Thomas A. Crews, M.Ed. C.P.M.
Correctional Programs Administrator
Bureau of Security Operations

CC: Jerry L. Vaughan, Deputy Director of Institutions
Richard Dugger, Deputy Director of Institutions
James R. Upchurch, Chief, Bureau of Security Operations

**MARTIN TREATMENT UNIT**
**JUNE 6-7, 2000**

➢ **Issues: Contract Issues**

- Secure Counts

  Issue:
  - Terms of the existing contract call for a count procedure. Liberty staff has a system similar to the FDC, however, it was not evident that this was common practice. (i.e. residents were counted outside in multiple areas after non-daylight hours and also prior to morning release for work/programming activities).

  Recommendation:
  - Count residents during all formal counts inside housing unit, rather than allowing them to be counted on recreation area

- Clothing

  Issue:
  - There is no formalized dress code for the resident population. Additionally, approximately 150 sets of gray uniforms were found in the resident laundry room.

  Recommendation:
  - The facility should adopt a standardized uniform dress code for the resident population. This would provide an easily recognizable method for determining who is a resident and who is staff/visitors.

- Control Room Staffing

  Issue:
  - Liberty officials are requesting authorization that a staff member be allowed to work in the control room – 24-7. They feel this would expedite response time to the needs of their staff.

  Recommendation:
  - Remove FDC staff from Control Room and relocate all perimeter monitors and gate controls to a new secure building at the sally port gate. This would be manned with 2 officers, the second officer coming from the Control Room. Would construct secure gatehouse based upon Okeechobee CI or Zephyrhills CI design.

  **OR**

  - Renovations to the current Control Room (inside) need to be made in order to allow for inclusion of one Liberty staff member to facilitate camaraderie and foster improved communications.

  **OR**

  - Continue current staffing pattern for FDC to provide control room duties to include the exterior doors and camera monitoring.

- Opening of outer doors/Not securing doors

  Issue:
  - Liberty staff felt that the response time of the control room officers was unacceptable and ultimately would prop open the doorway.

  Recommendation:
  - An open line of communication between the Liberty staff and the FDC officers should be re-emphasized and more patience exercised by both parties.
  - Stress to Liberty staff not to prop open the electronically controlled doors.

- Liberty staff uniforms

  Issue:
  - Staff uniforms worn by Liberty staff consists of a maroon golf style shirt and a pair of khaki pants. Similarly colored clothing can easily duplicate this look.

  Recommendation:
  - Proper inventory and security measures related to uniform control should be followed.
  - Do not allow Liberty staff to change clothing in bathrooms and leave clothing items in shift supervisor office.

- Communication

  Issue:
  - It was readily apparent that there is not an open/effective line of communication as required in the existing contract.

  Recommendations:
  - Monthly documented meetings between FDC, Liberty and DCF staff.
  - Bi-weekly meetings between FDC and Liberty administrative-level personnel.
  - Daily meeting between FDC and Liberty chiefs of security, or designee.
  - Immediate notification to FDC by Liberty of an EAC event-reporting category occurrence.

- Weapons

  Issue:
  - Per the existing agreement there are no weapons assigned to the FDC perimeter staff..

  Recommendation:
  - Staff at Martin CI requested that the perimeter officers be provided with weapons for self-defense in the event of an assault on their position from outside the facility. (At a minimum - .38 caliber sidearm with 18 rounds of ammunition). We concur with this request.

- DCFS Assessments

  Issue:
  - No DCFS assessments have been conducted that FDC staff has been made aware of.

Recommendation:
- The existing terms of the agreement, which allow for two such assessments per year, should be followed.

➢ **Issues: Physical Plant**

- Cross-Fencing

Issue:
- The existing cross-fencing needs to be relocated and enhanced.

Recommendation:
- Enhancing all short-barb razor wire with long barb.
- Enclose area within 50 feet either side of south door with fence fabric, long-barb razor wire, pedestrian gate, cameras and enhanced lighting.
- Replace fence around recreation area with McDougal fence, to include no-climb mesh and appropriate long-barb razor wire.
- Utilize 'bull-runs' to control movement between main building and exterior structures/recreation areas (fence fabric, cameras, remote-controlled gates, long-barb razor wire).

- Sewage Treatment Plant

Issue:
- The old plant is in the field just outside of the interior cross-fence that surrounds the recreation area.

Recommendation:
- Remove to exterior of compound. It should be noted that funding was provided in the April 1999 schedule of values to complete this project.

- Lighting

Issue:
- Interior compound lighting is adequate for the existing programming activities, however, if the program/wellness area is enlarged it will be necessary to add additional lighting enhancements.

Recommendation:
- Enhance lighting on basketball court and open recreation area

- Perimeter

Issue:
- Currently there are no crash barriers on the east side of the perimeter. This area is vulnerable to vehicle intrusion from the main access road.

Recommendation:
- Install crash barriers around eastside of the perimeter fence (at the entrance road area) to prevent breeching of this area by a vehicle

➢ **Issue: Security/Escape Concerns**

- Prevention

  Issue:
  - Procedures and materials can be put into place to prevent/deter escape attempts.

  Recommendations:
  - Pole-to-pole cable systems on open recreation field
  - Long-barb razor wire on main building roof line
  - One large tepee system on main building roof
  - Set specific time outside doors are locked in the evening hours–no non–emergency movement outside after secure lockdown.
  - Liberty staff need to move continuously through units rather than congregating in hallway around counters

- External Communication and Contact

  Issue:
  - Visitors, mail and telephone use is not properly or adequately supervised.

  Recommendation:
  - All areas should conform to current FDC procedures/Florida Administrative Code in relation to security.
  - Visitors should be properly screened and placed on approved visitation lists.
  - Mail should be appropriately reviewed.
  - Telephone lines should allow only collect calls and should be monitored for content.

- Identification

  Issue:
  - Identification of staff, residents and visitors is not readily apparent.

  Recommendations:
  - Liberty staff should prominently display their identification on their shirts.
  - Residents should wear digital photo identification cards at any time they are not in their individual housing unit/wing.
  - Visitors who do not possess a Liberty Behavioral Services, FDC or DCFS photo identification card should be properly identified and logged in and then issued an appropriate visitor identification card to be prominently displayed while at the facility.

**STATE OF FLORIDA**
**DEPARTMENT OF CORRECTIONS**

**COST ANALYSIS**

The following information is provided as a result of the meeting conducted at the Capitol on June 8, 2000, with members of the Governor's staff, Children & Family Services, and the Department of Corrections. The figures shown are in accordance with current information provided by Facility Services (FDC) and are associated with current state contract information or prototype construction costs.

**CENTER TOWER**

Construction costs $115,000 (force account project) + ($35,000 site work & utilities) = $150,000.
$225,000 + ($35,000 for site work & utilities) = $260,000

Equipment — This figure depends totally upon what the center tower is used for. If it is strictly for observation, than equipment costs could be very low. If electronic gate controls, camera monitoring, and electronic perimeter systems monitoring equipment is installed the cost could be extremely high.

Staffing — To man this post 7 days per week, 24 hours per day would require 5 positions. The current cost of a correctional officers salary is approximately $35,000 X 5 positions = $175,000 annually.

**ROVING ARMORY**

| | | |
|---|---|---|
| Weapons | 1 Smith & Wesson Model 10, .38 caliber revolver | $275 |
| | 1 Remington 870 Wingmaster 12 guage pump shotgun | $305 |
| | 1 Holster for the .38 caliber revolver | $57 |
| | 2 Speedloaders @ $10 per set | $10 |
| | 2 Speedloader cases @ $19 each | $38 |
| | | $685.00 |
| Ammunition | 1 case - .38 caliber round nose duty ammo | $130 |
| | 1 case – 12 guague 00 buckshot | $27 |
| | | $207.00* |

**LESS THAN LETHAL MUNITIONS**

| | |
|---|---|
| 3 MK OC Pepper Spray Aerosol (1 per perimeter post @ $10.50 ea.) | $31.50 |
| 1 dozen 12 gauge stinger round (32 caliber rubber pellets @ $4.20 ea.) | $50.40 |
| | $81.90 |

*OPPAGA note of clarification: the correct total is $157.00.

**Martin Treatment Center Comparison**
**July 1999 and June 2000**

➢ **Security Issues**

| Issue-July 1999 | Projected Completion Date | Status Update-June 2000 |
|---|---|---|
| ▪ Perimeter detection system not fully operational | September 1999 | Micro-wave system not fully installed and operational |
| ▪ Door inter-lock capability | Upon identification of funding sources | Money allocated; door locking mechanisms and control panel not yet on site |
| ▪ Installation of (2) walk-through metal detectors | Not completed | (1) metal detector was purchased, but has not been installed; the funds for the second detector were diverted for other security enhancements |
| ▪ Cameras, monitors and intercom system for main pedestrian gate | Awaiting identification of funding sources | Pending allocation of diverted funds, purchase and installation |
| ▪ Hand-verifier system | Upon identification of funding sources | Pending allocation of funds |
| ▪ Enhanced storage for sensitive medical items | August 1999 | Completed |
| ▪ Initiate security inspections | August 1999 | Completed |

➢ **Other Issues**

| Issue-July 1999 | FDC Recommendation | Current Status |
|---|---|---|
| ▪ Employee screening, hiring and licensing/certification process | Compliance with FS 435 as amendment to existing contract | No action |
| ▪ No random drug-testing of resident population | Contract be amended to include this stipulation | No action |
| ▪ No automated/monitored resident telephone system | Install system. Liberty administration advised that this would be accomplished by September 1999 | No action |
| ▪ Enforce resident handbook dealing with grooming, discipline, identification cards, etc. This should also include general rule adherence. | Amend contract to include the handbook. Liberty staff stated they would implement an 8-level behavioral management program, which would include discipline for rules violation. | No action |
| ▪ Procedures manual to address critical incident management and event reporting. | Clarify through contract responsible parties for critical incident response/action and event-reporting. | Critical incident management has been clarified through FDC and Liberty, however no action has been taken as to daily event-reporting categories. |

## *Appendix B*

# *Liberty Behavioral Health Care, Inc., Considerations and Constraints*

**Martin Treatment Center**
**1175 SW Allapattah Road**
**Indiantown, Florida 34956**
**(561) 597-1477** **Fax (561) 597-1484**

Date: June 19, 2000

To: Greg Venz, Director
Sexually Violent Predator Program

From: Robert Briody, Director
Martin Treatment Center

Subject: Steven Whitsett SVP # 990133

Escape Summary

On Monday, June 5, 2000, Mr. Whitsett escaped from the Martin Treatment Center (MTC) by helicopter. At 1:00 p.m. Mr. Whitsett climbed an internal fence west of the volleyball court in the MTC recreation yard and ran to board a small helicopter that just then entered the facility's perimeter from the south. He attempted boarding the helicopter before it settled to the ground by climbing on it's landing skids. Due to pilot error or aircraft imbalance the helicopter fell hard on the ground tilting to one side and the rotor blades hit the ground and Mr. Whitsett fell from the aircraft. He re-boarded the helicopter and it took off heading south. It had difficulty attaining any altitude, crossed the perimeter fence with little clearance and crashed approximately 50 yards from the outermost external fence. Mr. Whitsett and the pilot of the aircraft, Mr. Cliff Burkhart, ran from the crash site, heading south in the orange groves. At approximately 2:30 p.m. on Tuesday, June 6, 2000, they were spotted by field workers in a canal several miles east of MTC and were shortly thereafter taken into custody by a Martin County Deputy Sheriff. They are currently being held at the Martin County Jail.

Mr. Whitsett arrived at MTC on September 13, 1999 and consented to treatment on December 21, 1999. Staff viewed him as manipulative and willing to challenge policy and test limits. He did not engage staff in angry exchanges, oppose their authority, or behaviorally act as a management problem. In October 1999 staff observed him carrying an alpha-numeric pager. It was confiscated and was mailed from the facility. Although it was never confirmed, it is believed that he received the pager from a visitor. In November 1999 he requested permission to have a cellular telephone at MTC. This request was denied. In December 1999 he received a desktop computer in the mail. He was not allowed to have it, and it was subsequently returned in the mail. He managed to have his attorney obtain a court order for him to have the laptop, but it was still not given to him, and in a hearing before the judge who signed the court order, the order was vacated at my request after providing testimony. A total of seven (7) Incident Reports were filed regarding Mr. Whitsett from September 1999 through May 2000. These involved the incidents discussed above as well as other infractions of rules of a minor nature and one incident of a minor injury.

Mr. Burkhart visited Mr. Whitsett at MTC on ten (10) occasions from February 6, 2000, through June 4, 2000. Two (2) of these were special visits prior to Mr. Burkhart being approved as a regular visitor and being placed on Mr. Whitsett's approved visitors list. [12] One of the special visits was cancelled due to renovations inside the MTC building. During all visits Mr. Burkhart followed MTC rules, and never aroused suspicions of staff or drew attention to himself as a visitor. Mr. Whitsett was visited by his mother and father on five (5) occasions, from January 1, 2000, through May 27, 2000. All visits were unremarkable and occurred without incident.

On May 28, 2000, Mr. Whitsett sent the following items home: books, a hat, compact disk player, various CDs, and a headphone. The compact disk player was reportedly not working, and in recent months many MTC residents have been sending some personal possessions home because property limitations have been more stringently enforced. Immediately after the escape it was learned that Mr. Whitsett's storage (foot) locker was empty. Apparently he had given his clothing and other authorized items to other residents. It has been learned that Mr. Whitsett was saying that he would be leaving for court on June 5 or 6, 2000, and that his attorney had assured him that he would be getting released and not returning to MTC.

On the morning of June 5, 2000 at approximately 10:00 a.m., Mr. Whitsett received a haircut. At 12:35 p.m. he was interviewed by two MTC staff members to work as a clerk in a property supply room. He told the interviewing staff that he got the haircut to look good for the interview as he really wanted this job, and showed no conspicuous signs of anything out of the ordinary. He went to the recreation yard at 12:45 p.m. while open recreation was in progress.

Three Therapeutic Assistant staff were on the yard at 12:45 p.m., and several clinical staff were going to and coming from the double wide trailer that serves as an office building for clinical staff. At this time Mr. Whitsett was standing near the fire exit door of Ward Four and the gate between the volleyball court and the office trailer. As 1:00 p.m. approached, two of the Therapeutic Assistants entered the MTC building with a number of residents. The Therapeutic Assistants were enroute to a staff training class and two other Therapeutic Assistants were being assigned to the recreation yard. At 1:00 p.m. one Therapeutic Assistant and approximately 40 residents were on the yard. As the helicopter passed over the office trailer Mr. Whitsett was seen by Mr. Larry Barriner, the Therapeutic Assistant on the yard, on the west side of the internal fence waving at the helicopter. Mr. Barriner radioed MTC central control that an escape was in progress and provided instructions. Moments after the escape the MTC resident population was placed on lock-down status and all staff were accounted for. A population count verified that Mr. Whitsett was not in the facility.

When apprehended on June 6, 2000 Mr. Whitsett and Mr. Burkhart were reported to have $10,000 in cash and two pistols in their possession. The pistols were apparently on board the helicopter when he landed inside the MTC perimeter. In an interview at the County Jail on June 8, 2000, Mr. Whitsett stated that he had been planning the escape for two months and that the original plan was for the helicopter to land on the MTC basketball court. He also stated that he had not shared with any MTC residents his plans or intentions for making the escape.

<u>Considerations for Reducing Escape Risk</u>

1. MTC central control staffing was reduced to one Department of Corrections (DOC) officer. The tasks and responsibilities on that post are more than one person can handle efficiently, especially in an emergency situation. Increasing the number of Liberty full time staff so that a Therapeutic Assistant can be assigned to central control would improve internal security and emergency response. (Placing Liberty staff inside the MTC central control was recommended to DOC approximately one year ago).

[12] OPPAGA note of clarification: the first special visit occurred on February 6, 2000. However, when Burkhart arrived at the facility, he was denied the visit due to some renovations being made. Because this visit was cancelled, he was allowed to come again so see Whitsett on February 15, 2000. Both visits were approved by Robert Lay, a Liberty employee who was Whitsett's case manager.

2. Setting specific minimums on the number of Therapeutic Assistant staff on the recreation yard may not prevent perimeter penetration, but may reduce staff reaction time.
3. Increasing the number of Therapeutic Assistant floor staff from original contract limits my be advisable. Upon implementation of the MTC SVP program by Liberty, several additional responsibilities have become incumbent upon Liberty to fulfill. These include: operation of a laundry, a canteen, a property storage area, resident basic issue and supplies, and internal janitorial duties. These responsibilities require the dedication of Therapeutic Assistant staff time (three full time positions) that was not originally considered.
4. Observation towers, instead of stationary vehicles on the perimeter road, may increase earlier detection of approaching external threats.
5. Requiring that a minimum of one vehicle be in motion at all times on perimeter road may increase earlier detection and response to an approaching external threats.
6. Prohibiting DOC inmates from loitering inside the sally port area, between the two external perimeter fences, will increase safety and reduce possible risk of the gate officers being overpowered.
7. Placing razor wire on the edge of the top of the MTC building to prevent possible efforts of residents to climb on the roof of the building may reduce the likelihood of a planned helicopter assisted escape from the top of the building.
8. Improved lighting on the MTC yard and increasing the number of light poles on the yard may reduce the opportunity for a helicopter landing. Criss-crossing cables from tops of the light poles may further improve yard security.
9. Arming perimeter officers and authorizing them to shoot at helicopters violating the MTC facility airspace upon attempting to exit, may reduce risk.
10. Removing the window tint from the MTC central control would allow MTC staff to view opposite sides of the central control area floor and ensure better population management, especially during times of crisis or internal disturbance.
11. Increasing the number of internal and external security cameras could prove helpful. Improved maintenance of existing cameras and tapes and preserving tapes for one week would also be helpful.
12. Building and site enhancements should be promptly completed once started. Installation of internal security and fire doors, begun in January 2000, remain incomplete. Proposed lighting, fencing, and paving around the facility begun in 1998 has not been completed or worked on since July, 1999.
13. Improved communications:
    A. Quarterly meetings between DOC, DCF, and Liberty could address and help resolve local concerns.
    B. Regularly scheduled weekly meetings between MCI and Liberty executive staff could provide regular follow-up on facility maintenance and security.
    C. Attendance at the daily management meeting at MTC by the DOC Major assigned to MTC would ensure improved communication about high risk situations and residents.
    D. A DCF staff member to serve as a liaison for communication with DOC and as a Public Information Officer would be beneficial.
14. Internal fences at MTC could be re-configured to improve security by allowing better controlled movements of residents, and increase recreational opportunities.
15. Weekly security rounds of the entire MTC facility, inside and outside, by the DOC Major and the MTC Therapeutic Community Manager should take place.
16. An outside audit by the Mercer Group in the fall of 1999 recommended that either Liberty or DCF supervise all MTC staff and operations, including DOC staff, for improved security. In this regard, no changes were initiated.
17. Originally, pursuant to interagency agreements, DOC at MCI provided training for Liberty staff on a variety of security and support matters. Since the regionalization of training by DOC this training has been unavailable. Consequently, Liberty has

had to independently contract for this training and prompt and regular scheduling has been difficult. Therefore, increasing Liberty staff to include a Training Officer will compensate for the loss of DOC approved training.

18. Transmission of information could be expedited if the MTC facility had phone lines that could allow computerized electronic mail communication.
19. Staff phone lines at MTC are frequently non-functional. Weather (moisture in the ground) and other variables effect MTC's ability to receive and transmit telephone calls.
20. The DOC report on MTC security dated July 22, 1999 recommended the installation of two walk-through metal detectors. This has not been completed.
21. A hand verifier system that was described as "extremely critical" in the July 22, 1999 DOC report has not been purchased to improve security.

Constraining Factors

1. The MTC building was originally built as a jail, a temporary detention facility for misdemeanor and some felony subjects pending charging. Given that in design and architecture "form follows function", the building floor plan is poorly suited for the indefinite and long term detention and commitment of a population of felons who are violent, predatory, and mentally disoriented. In this regard the building:
    A. Lacks adequate space for storage of personal property.
    B. Houses residents in jail type common living units for approximately 14 residents, per ward, instead of individual cells or rooms.
    C. Is without sufficient space for office and treatment rooms.
    D. Is without internal recreational areas.
    E. Is without adequate internal leisure areas.
    F. Is without a properly designed or adequately sized outside area for recreation and leisure activities.
2. To accommodate SVP detention and commitment a maximum security perimeter fence was installed. Certain enhancements were not completed and no mechanism has been developed to address these issues, or other issues that affect security.
3. Civil detention and commitment relies upon therapeutic intervention coupled with supervision of privileges for managing and controlling the conduct of residents. The limitations imposed by the MTC physical plant promotes considerable idleness in a milieu where few privileges can be suspended and a small outdoor recreational area must be liberally used.

Martin Treatment Center Staff Review

The June 5, 2000, escape by Steven Whitsett has resulted in a full review of policy and procedure by the staff of the Martin Treatment Center. The following comprised the review process components:

- Review of the clinical documentation regarding Mr. Whitsett. The clinical documentation denotes that he was resistant, closed and controlling. Mr. Whitsett never took full responsibility for his behavior. While he missed very few group sessions, his participation was seldom genuine and he remained manipulative, resistant to treatment and non-disclosing.
- Review of Incident Reports involving Mr. Whitsett.
- Review of Mr. Whitsett's behavioral record.
- Review of visitation documentation regarding Mr. Whitsett, and visitation policy and procedure.

- Review of Mr. Whitsett's personal property inventory and documentation, and resident property policy and procedure.
- Interviewing staff and residents regarding the events of June 5, 2000, leading up to the actual escape, the escape incident itself, and all events following the escape.
- Review of security procedures and supervision of residents.
- Review of the December 12, 2000 *Mercer Report: Study of Programmatic and Facility Needs of the Florida Sexually Violent Predator Program* and the February 1, 2000 *Jimmy Ryce Act Enforcement Task Force Final Report* which both make the same findings:
  - The wards, as presently designed, are not suitable for long-term housing.
  - Staff offices are in a trailer that is separate from the main building. This makes it difficult for staff to be readily accessible to residents.
  - Treatment space is limited and acoustics make it difficult to maintain confidentiality and to focus on the topic at hand.
  - The physical plant of the Martin Treatment Center is awkwardly arranged to serve as a viable SVP civil commitment facility.
- Review of program staffing and training needs.

This review process is continuing, has resulted in some preliminary recommendations, and will culminate in a full administrative review with appropriate revision.

Respectfully Submitted:

/s/ 6/19/00

Robert Briody, Ph.D. Date
Executive Director

## *Appendix C*

# *Study of the Programmatic and Facility Needs of the Florida Sexually Violent Predator Program*

**William M Mercer, Inc.**
**Final Report, December 20, 1999**
**Study for the Department of Children and Families**

***Recommendations for Martin Treatment Center***
***(Excerpts from the full Report)***

- The DCF should be responsible for all aspects of the operation of the Martin Treatment Center (security, treatment, maintenance and others). DCF staff (presently contract employees) should operate the internal control center instead of DC employees. A DCF staff should also be present at the ingress/egress post to process and receive all visitors.
- All, visitors should be required to pass through a walk-through metal detector.
- Inmate maintenance workers should not be allowed to perform work in the Martin Treatment Center.
- Procedures should be developed which prohibit staff from using the same restrooms as residents.
- The program operations manual should be immediately revised to reflect the actual practices being used to search visitors and residents.
- Visitors under the age of 18 should not be allowed under any circumstances.
- New identification cards that do not identify treatment center staff as "DC" employees should be used.
- The DCF should meet with the DC to explore the development of a protocol that allows for alternative restraint devices for certain residents leaving the facility for court appearances, medical appointments, and other appointments. Leg brace restraints, which can be worn under the pants, should be considered.
- The perimeter security system is consistent with systems used in several other states.
- Existing dorm areas must be modified as soon as possible to make them more suitable housing units.