

MARJORY STONEMAN DOUGLAS HIGH SCHOOL
PUBLIC SAFETY COMMISSION MEETING

BB&T Center, Chairman's Club
1 Panther Parkway
Sunrise, Florida 33323

July 12, 2018

8:30 a.m. - 5:30 p.m.

1 COMMISSION MEMBERS/ATTENDEES:

2 SHERIFF BOB GUALTIERI, Chair

3 RICHARD SWEARINGEN, Commissioner - Florida

4 Department of Law Enforcement

5 MAX SCHACHTER, Parent of Victim

6 LARRY R. ASHLEY, Sheriff - Okaloosa County (via
phone)

7 MELISSA LARKIN SKINNER, CEO - Centerstone of Florida

8 MICHAEL CARROLL, Secretary - DCF

9 JAMES HARPRING, Undersheriff/GC - Indian River
10 County

11 GRADY JUDD, Sheriff - Polk County

12 LAUREN BOOK, Senator - District 32

13 RYAN PETTY, Parent of Victim

14 BERTHA HENRY, County Administrator

15 SHAWN BACKER, Deputy Chief - Coral Springs Police
Department

16 BRAD MCKEONE, Operations Deputy Chief - Coral
17 Springs Police Department

18 KATHY LIRIANO

19 KEVIN LYSTAD, Chief/President - Florida Police Chief
Association

20 DOUG DODD, Commissioner - Citrus County School Board

21 MIKE MOSNER, Assistant Chief - Coral
22 Springs/Parkland Fire Department

23 CINDY CAST - Miami-Dade Communications

24 ROBIN SPARKMAN, Chief of Firearm Eligibility Bureau
- Florida Department of Law Enforcement

25 UTE GAZIOCH - Division of Child and Family Services

1 JUSTIN SENIOR, Secretary - AHCA

2 SILVIA QUINTANA, CEO - Broward Behavioral Health

3 STEVEN LEIFMAN, Judge - Chair of Florida Supreme
Court's Task Force on Mental Health and Substance
4 Abuse Issues

5
6 Also present:

7 DAVID COBRA CLEMENTE, Chapter Leader - Parkland
Guardian Angels

8
9 JEFF OSTROFF

10 MICHAEL SIRBOLA

11 I-N-D-E-X

12 PAGE

13 PUBLIC COMMENTS

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1 (Thereupon, the following meeting was had:)

2 CHAIR: All right, we're going to get
3 started. Before we get with Chief Backer we're
4 going to hear from the County Administrator
5 this morning, but before we do that let me just
6 kind of recap. In talking to some people, I
7 just want to make sure that the commission
8 members have an understanding of the importance
9 of yesterday, what we're going to wrap up this
10 morning, and why we're going through this.
11 There's been a lot of discussion, and some
12 criticism about what people did, what people
13 didn't do, why they acted, why they didn't act,
14 and an important aspect of us evaluating that
15 is what people knew, what they didn't know,
16 information that they had access to,
17 information that they didn't have access to,
18 that may have driven some of their actions or
19 inactions.

20 So, that was a significant reason and
21 backdrop for having to go through all of what
22 we are going through regarding communications.
23 And when you think about it this way, and what
24 we learned yesterday, and what we know, and
25 this is going to lead us into August, and

1 especially into September for sure, but
2 hopefully in August as well, where we're
3 starting to really look at in a detailed way,
4 you know, with facts, and with evidence, and
5 call logs, and CAD notes, and radio traffic,
6 and everything else putting this whole picture
7 together is, is that what we learned yesterday
8 is, is that if somebody at Marjory Stoneman
9 Douglas High School dials 911, is that we know
10 that that is going into the Coral Springs
11 communications center, and that's where that
12 call is going to be answered. We know that the
13 Coral Springs Police Department is not the
14 primary law enforcement responder at Stoneman
15 Douglas High School, we know that the Broward
16 County Sheriff's Office is.

17 We know that the way the system is
18 designed is, is that the Coral Springs Police
19 Department when they answer that call, and
20 somebody says there's a law enforcement
21 emergency at Stoneman Douglas, that they would
22 transfer that call to the Broward County
23 Sheriff's Office regional communications
24 center. That call taker would then ask the
25 person certain questions again. That person

1 would convey the information. They would
2 create an entry into the CAD system, meaning
3 the call taker would create an entry into the
4 CAD system. That entry would then be shipped
5 to the dispatcher. The dispatcher would then
6 send it out over the Broward County Sheriff's
7 Office CAD and/or radio system.

8 And what we know happened on February 14th
9 is, is a lot of 911 calls went into the Coral
10 Springs Police Department Fire 911 Center. We
11 don't know how many calls, and we're going to
12 find out, and you'll have that in front of you
13 in the near future. We don't know how many
14 calls went to the Broward County Sheriff's
15 Office regional communications center. A few,
16 but not a lot. The exact number we'll find
17 out.

18 We also know that the Broward Sheriff's
19 Office does not have a CAD system that they
20 share with Coral Springs, so as Coral Springs
21 was getting that information, and they were
22 entering it into their CAD, and their officers
23 were getting it, the Broward County Sheriff's
24 deputies who are being informed of the active
25 shooter situation at Stoneman Douglas didn't

1 have access to the CAD information that was
2 being entered in the Coral Springs system.

3 We also know that the Broward Sheriff's
4 Office regional communications center did not
5 have the Coral Springs main dispatch channels,
6 so they couldn't even go up on those channels
7 to even hear what Coral Springs was saying. We
8 also know that the responding deputies didn't
9 have access to the Coral Springs primary
10 channel. Then we heard as well about the
11 responding deputies, and we heard a lot about
12 this thing that has become infamous, in
13 throttle, and you were told that when the radio
14 system's capacity is met, in essence is, is
15 that this throttling thing happens, and that
16 whoever is trying to talk can't talk.

17 So, the version of it, this is what
18 happens, is that if a deputy gets there, and in
19 this case Captain Jordon got there, and a lot's
20 been made about what she did or didn't do. And
21 she gets on the radio to try and take control
22 of the situation, (radio sounds) what's she
23 going to do, thing becomes a brick, turn it off
24 and throw it away, there's nothing you can do
25 with it. That's what she was getting. That's

1 throttling. That's the type of tones that
2 you're getting.

3 So, when people are saying that in Captain
4 Jordan's case, and I don't know Captain Jordan,
5 I met her once for about maybe five seconds, I
6 don't know whether she did a good job, poor
7 job, or somewhere in between. I have no idea.
8 But what I do know, and the evidence here is
9 going to show, and where it's going to show,
10 because the testimony of law enforcement
11 officers and body cam video and audio that
12 shows that she was trying to transmit, and she
13 couldn't transmit, and she could not get on the
14 radio to take control of the scene, and that
15 she was trying to go to their radios, car
16 radios, K-9 deputies' radios, cruiser radios,
17 she was trying to get on there and she couldn't
18 get on there.

19 All that is extremely relevant to our
20 evaluation of the command and control, which is
21 one of the things specifically we're charged
22 with evaluating here, and whether there was
23 adequate command and control, and whether the
24 scene was handled properly, and whether
25 decisions were made. And so, as there is

1 criticism of, and it's been in public, public,
2 about whether she allowed EMS in, whether she
3 didn't allow EMS in, whether she set
4 perimeters, whether she did this, which she
5 did, she couldn't communicate. And the
6 evidence that we see, and what you're going to
7 see more of is, is that there is no doubt that
8 the information that was available to Coral
9 Springs exceeded the information that was
10 available to Broward County Sheriff's Office
11 because they didn't have a shared channel, they
12 didn't have a shared CAD, and that people were
13 trying to communicate, and they couldn't
14 communicate because of this throttling issue.

15 So, in order for us to have a clear
16 understanding of what we are going to see in
17 great detail moving forward I felt that it was,
18 and still feel it is, extremely important that
19 you have a working knowledge, and an
20 understanding of everything leading up to it,
21 and the background, and the framework, so that
22 you can properly evaluate what happened, what
23 people did and what they didn't do, and why
24 they may have acted, and some may have acted
25 and others may not have acted, and it may have

1 been driven by the knowledge they had and the
2 information available to them because they
3 didn't have the ability and the capability of
4 knowing what others knew because you had stuff
5 that was going out over one system that wasn't
6 on the other system, and you had information
7 that's flowing into one place that wasn't
8 flowing into another. How much we'll find out.
9 Because that's the way the system was set up.

10 And remember what I suggested to you at
11 the beginning back in April as we go, as we
12 look at all this, there's a difference between
13 human failure, individual failure and people
14 failure, than system failure. If the laws, the
15 policies, the protocols, everything that's set
16 up is right, but people implement it poorly,
17 that's a different issue then whether there's a
18 problem in the structure. And if people acted
19 but they didn't get the right result, but it
20 wasn't because of their incompetence, or their
21 inability, or their lack of something, it's
22 because the system didn't allow them to
23 implement what they wanted to implement, it's
24 two different issues.

25 And that's one of the things that we got

1 to try to figure out there as we move forward,
2 is this a people problem, is this a system
3 problem, or is it both. I don't know the
4 answer to that as we sit here, but for sure I
5 can tell you that what is relevant is what
6 people knew, when they knew it, and why they
7 acted or didn't act based upon the information
8 they had. And that's why we got to go through
9 all this, so that you have an understanding as
10 to the systems, the CAD, the radio channels,
11 and the ability to get information and to
12 communicate it.

13 So, with that, I just wanted to recap
14 that, a kind of where we are as we move into
15 this morning. So, does anybody have any
16 comments, thoughts, questions before we get
17 started? Senator Book.

18 SEN. BOOK: Thank you, Mr. Chair. And as
19 I was reviewing my notes yesterday, and we'll
20 probably get into this, but the who
21 communicates with who, if Deputy Peterson was
22 on his radio and setting protocol as the first
23 on the scene who got that, who got that, only
24 BSO, or --

25 CHAIR: Only BSO. He had two radios. One

1 was the school radio that he was communicating,
2 and that school radio is really like a walkie-
3 talkie, you can go to Walmart and buy it. It's
4 a walkie-talkie, and it's not recorded, it's
5 not on any type of a system, it's really just a
6 school- based walkie-talkie system. And so, he
7 had that radio, but the law enforcement radio,
8 the public safety radio he had was a Broward
9 County Sheriff's Office radio. I believe he
10 was on channel 8A, which is the Parkland
11 channel, the main channel for Parkland, and the
12 people who would have heard his transmissions
13 would only have been Broward County Sheriff's
14 Office dispatch and Broward County Sheriff's
15 Office deputies on 8A.

16 Now, would other Broward Sheriff's Office
17 personnel have heard that, only, okay only if
18 they changed their radios over to 8A, or they
19 were scanning channels. And to be honest with
20 you, some deputies scan, and some deputies
21 don't. So, remember you heard about all the
22 different zones, and you heard about all the
23 different channels, we you can put the radio on
24 scan, where with what you have in your scan
25 capability you can scan a whole range of

1 channels and talk groups. But if you are in
2 zone, if you're on 3Alpha as opposed to 8Alpha,
3 and you don't have it on scan, Deputy Peterson
4 can be talking all day long and you're not
5 going to hear it.

6 So, the ones that would definitely hear it
7 are those that are on 8Alpha, only Broward
8 Sheriff's Office, and those that were scanning.
9 But Coral Springs, or Hollywood, or Fort
10 Lauderdale, unless they went over there they
11 wouldn't, well, they wouldn't have heard it.

12 SEN. BOOK: But it's recorded?

13 CHAIR: It's recorded. Sheriff.

14 SHER. JUDD: Let me reconfirm what our
15 Chairman said, in the sense that when you look
16 at systems and processes, and that's what we do
17 in our business in this world, if you don't
18 have the appropriate system there is always
19 going to be a series of cascading events
20 downward. So, if you don't have the system and
21 the process in place, and I'm not speaking to
22 what training they had or didn't have, when a
23 vast emergency occurs, and this is a vast
24 emergency, there is going to -- when systems
25 fail, and people have to depend on those

1 systems, then the people are going to fail.
2 And it's -- it is a, the direct causation is
3 not having the appropriate systems and
4 processes in place. So, when -- and I don't
5 want to jump ahead of the testimony, but you
6 can't help but bring decades of experience in
7 here, and when we see this bifurcated system,
8 and then you start to put hundreds of first
9 responders into this vast emergency all at one
10 time, there's going to be a system failure.

11 Under the best trained best equipped, best
12 trained people, best equipped systems and
13 processes, the first little while is total
14 chaos, because you go from a normal day to
15 having to ramp up for a major emergency. When
16 a Hurricane is coming, and we're darn good at
17 it in the state of Florida, preparing for it,
18 dealing with it, and the aftermath, we have a
19 week or two for this major event, to prepare
20 for this major event, and we have systems and
21 processes that we put in place because of past
22 failures, and it still stresses everything that
23 occurs.

24 Now imagine if we're sitting here on a
25 sunny afternoon in South Florida and the

1 Hurricane occurs overhead right now. If we
2 have the right systems it takes a while to get
3 it going, and when we look at this clearly the
4 people on the ground trying to make sense of
5 this were in towers of babble, and, you know,
6 my position is not going to change.

7 If you want to do what's ultimately best
8 with a system everybody gets on that regional
9 system, and then they figure out the different
10 nuances that's in the best interest of their
11 particular city. And you have to make sure
12 that system, the CAD system, the radio systems
13 have, are robust enough to handle all the, all
14 of those events. Then we can look at the
15 other, the other events.

16 But I'll end today where I started, it all
17 comes down to local politics, and local
18 control, and are you interested in that or are
19 you interested in what's ultimately the best
20 response for the citizens. I know from a vast
21 amount of experience that your local public
22 safety people desire to get the best resources
23 to people to save lives and to protect them,
24 and you can do it with one united regional
25 system that's sensitive to the different

1 communities' needs.

2 CHAIR: And some of the people, to add on
3 to that, some of the people that are tasked
4 with carrying out the processes that are in
5 place today are not the people that made the
6 decisions about the processes, so some of these
7 decisions were made -- this isn't necessarily a
8 Chief Perry, Chief Backer, Sheriff Israel,
9 County Administrator Henry, other -- this has
10 been in place for a long time, and you have
11 some elected officials who probably made these
12 decisions along the way that aren't even here
13 anymore.

14 So, some of these people that are tasked
15 today with trying to figure this out I would
16 venture to say, and from discussions, are as
17 frustrated with what they have to work with as
18 others are about it. So, the decisions were
19 not necessarily there's, and they may not even
20 agree with those decisions, but they weren't in
21 a position to make those decisions, they didn't
22 make them, but they're stuck with what they
23 got, and they're trying to get it to the best
24 place they possibly can, so you have to keep an
25 open mind to all that as well, is, is that, you

1 know, don't kill the messenger. Is that the
2 people who are, that we're hearing from today
3 for the most part as far as I know weren't here
4 thirty years ago, when that system was
5 implemented, as far as it relates to the radio
6 system.

7 Some of the decisions in '13 on the CAD,
8 some of them, some of them were and some of
9 them may not have been, is that the decision
10 makers then may be different people. This is
11 all stuff we're going to figure out, and we
12 just, you know, we keep an open mind to it.
13 But Mr. Schachter, go ahead.

14 MR. SCHACHTER: We are all here obviously
15 because of this tragedy, but this is a national
16 emergency we have with these school shootings,
17 and this, I thank you so much, Chairman for
18 what you said, and Sheriff Judd, but if we just
19 focus on this issue -- there is a greater
20 problem here, and everybody needs to come at
21 this with the mindset that if we don't stop the
22 attacker, and we don't prevent death in the
23 first couple of minutes it's all over. So,
24 this -- the PROMISE -- this situation is so
25 enormous, and that's why it's even so much more

1 important that we fix these issues on a
2 systemic level, because it happens so quickly,
3 and you're talking about chaos, and everybody
4 is going to die if you do not get a handle on
5 the situation and put the systems in place so
6 people can do their right job and save lives.

7 This -- again, I said this yesterday, and
8 I'll say it again, this happened, and everybody
9 was passed way in just over three minutes. You
10 look at Santa Fe, you look at these disasters,
11 it is happening so fast. That's what everybody
12 needs to keep in mind.

13 CHAIR: Sheriff Ashley.

14 SHER. ASHLEY: Just to piggy back on that,
15 I can't believe that communications is still an
16 issue after 9-11. We still have these vast
17 array of systems where there is no
18 consolidation, where emergency services can all
19 communicate with each other regardless of what
20 jurisdiction you're in. I think it has to be
21 legislated and mandated if it's every going to
22 change, because I know it won't happen in my
23 county unless they're forced to do it.

24 I've been dealing with trying to
25 consolidate communications for the last eight

1 years, and just now getting part of doing that
2 now, so I think if any recommendation, and I'm
3 not a wordsmith, but certainly this, this body
4 should recommend to our legislatures that that
5 be mandated for at least a regional level
6 communications for emergency services.

7 CHAIR: All right, before we begin with
8 hearing from testimony, presenters this
9 morning, does anybody else have anything they
10 want to -- no, okay. So, you heard a lot
11 yesterday from Broward County Government. I
12 mentioned to you that the Broward County
13 Administrator Bertha Henry couldn't be with us
14 yesterday. You heard a number of people who
15 work for her testify and provide us with
16 information. But the County Administrator is
17 here this morning, and I told her I'd give her
18 an opportunity to address the commission, and I
19 know she's willing to answer any questions that
20 you have, so I'd ask County Administrator
21 Bertha Henry to come up, and welcome, and thank
22 you for joining us this morning.

23 MS. HENRY: Thank you, Chief Gualtieri,
24 and members of the task force. First, I'd like
25 to again thank you all for allowing our team to

1 present in my absence. My -- the summary of
2 the session yesterday was that things went very
3 well, in the sense that we all are getting a
4 better understanding of the issue. And, Chief,
5 your recitation of where we are I think is
6 really spot on.

7 I also believe that this tragedy has
8 brought about a sense of urgency. The members
9 of the public safety community are coming
10 together. We know what we have to do here in
11 this county, and folk are committed to doing
12 that. On behalf of the Broward County
13 Commission I want to again affirm that we are
14 committed to building the best system that is
15 technologically available today for our
16 community. This has never been an issue for
17 Broward County, of resources, number one.

18 Number two, we recognize that putting this
19 system together is huge. It has a lot of
20 components, and you all heard a lot about how
21 the system is integrated. But again, I'd like
22 to assure you that we're moving as
23 expeditiously as possible. We recognize that
24 we have one or two gaffs that we're working
25 through, but it doesn't mean that we're not

1 working. There are a lot of things that happen
2 concurrently, that can happen concurrently, and
3 they are happening concurrently.

4 We also recognize that an incident can
5 happen in the next hour, and this educational
6 process that we've all been going through
7 certainly has heightened at least our awareness
8 of things that we need to be very sensitive to,
9 and we are. Again, I want to thank you all for
10 giving us the opportunity to at least share
11 that whatever cog in this wheel that belongs to
12 the County you can count on us to, to move it
13 forward. We take this very seriously, and I'm
14 hoping by the time this committee completes its
15 work that the piece that we have in this
16 ultimately meets with your, your satisfaction,
17 and that of the rest of our community.

18 And with that I'll answer any questions
19 that you might have.

20 CHAIR: Any commission members have
21 questions for the County Administrator? Okay,
22 Mr. Schachter, go ahead.

23 MR. SCHACHTER: Thank you very much for
24 coming in before us and talking to us. Can you
25 please explain to the commission what is the

1 hold up in putting the new radio system online?
2 It keeps -- it keeps getting delayed. And I
3 understand it's an enormous project. Can you
4 please elaborate on the problems? For me,
5 testify that my fear is, you know, if there's
6 another mass casualty event the FBI has said
7 that they're worried about contagion, they're
8 worried multiple attacks happening at the same
9 time, and currently if the same thing happens
10 again there's no reason in my mind to think
11 that we're not going to have the same problems
12 all over again. We need that system up as soon
13 as possible.

14 MS. HENRY: So, the first thing that I
15 would, that I would say, is that the system,
16 there are two components of what we're doing
17 right now. As you all may have heard the new
18 system that we're building will be limited to
19 public safety. Today there are some local
20 government activities on that, on that system.
21 We are moving them to a local government radio
22 system.

23 The local government radio system is,
24 should be available first quarter 2019. With
25 that we did have somewhat of a delay in that,

1 and I'm advised that you're aware that the
2 company that we worked with went out of
3 business. As it relates to the main public
4 safety radio system we, first there is an
5 engineering of the system, as you well know.
6 That system has been engineered to accommodate
7 nearly seventeen towers. Those towers are
8 three hundred plus feet, plus, to give maximum
9 coverage for the community. Today we have
10 commitments for all but one, and we expect to
11 hear very shortly from the one community that
12 we would like to use as a host of that last
13 tower. And once that's done we're -- the
14 system is already engineered for that, and when
15 that happens it's done.

16 What we're doing now, you have to
17 construct these towers in, in many instances,
18 so we're constructing the towers. We are
19 building bunkers around those towers. We
20 recognize that this is public safety, and just
21 as we're concerned about building the
22 technologically advanced system we're also
23 committed to building the safest system, so we
24 want to make sure that the money that our
25 community is investing in those towers and that

1 system, that we, that we protect it, that we
2 make sure that, as you've indicated, that, that
3 there is a concern that if you were going to
4 have some issue that it could spread throughout
5 the community.

6 The system has all sorts of redundancies,
7 but one of the things that we feel very
8 strongly about is that, that we know who is on
9 that tower, who is anywhere near that tower at
10 any given time because of its criticality to
11 public safety. So, we're moving forward.
12 Hopefully the community will give us an answer.
13 We met with them a couple of weeks ago. We
14 expect an answer any day. And once we have
15 that answer then we can govern ourselves
16 accordingly.

17 MR. SCHACHTER: Is that community Tamarac,
18 and is it true that you've been working with
19 Tamarac for a long, long time already, and that
20 is the only holdup, and that needs to be taken
21 care of?

22 MS. HENRY: That's the only -- well, first
23 yes, the community is Tamarac. And second,
24 that's the only remaining tower that we need to
25 have a resolution to. And as I said we met

1 with the City as recently as a couple of weeks
2 ago, and they've committed to giving us their
3 answer very shortly. But in the meantime, we
4 are building out the rest of the system.

5 MR. SCHACHTER: And if you don't get -- if
6 Tamarac doesn't -- that's the only last cog in
7 the wheel, if they don't say that we can put
8 the tower there what then, and you know, it
9 just needs to get done as soon as possible,
10 that's all we're waiting on.

11 MS. HENRY: So, if once we hear from the
12 City my board will have some decisions to make,
13 and, and I'm sure they're prepared to make
14 them. At this point I don't think there are
15 any other delays, because again, because we're
16 building out bunkers to protect these towers
17 and the systems that operate within those
18 towers. All of the communities that have to
19 host them have agreed to expedite the
20 permitting. It's just been -- this tragedy has
21 really brought about a sensitivity to how
22 fragile things can be, and how as a community
23 we all need to come together and move this
24 issue, and, and they're committed.

25 I have faith that we'll, that the City

1 will respond positively to what's going on.
2 Ultimately, they have some concerns about the
3 height of the tower in their community, and,
4 and we do understand that, but ultimately,
5 ultimately, I think we're all committed to
6 public safety. And you can have an unsightly
7 tower, or you can have real communication gaps,
8 and I'm hoping that they come to that
9 conclusion as well.

10 MR. SCHACHTER: Okay.

11 MS. HENRY: Any other questions?

12 MR. SCHACHTER: Thank you very much.

13 CHAIR: Sheriff Judd, yes.

14 SHER. JUDD: Thank you for being with us
15 today. Your words are very encouraging. You
16 all are on the game. Please remind Tamarac the
17 grades are six-foot-deep, and we're not really
18 concerned about the height of a tower if it
19 saves lives, that we need a sense of urgency.
20 This commission is here to not only investigate
21 what occurred but to make sure that things
22 occur that need to occur so that we reduce the
23 probabilities as much as possible of this ever
24 occurring again, and it starts with
25 communication. If we can't talk you can't

1 appropriately react.

2 And Tamarac needs to understand and
3 respond as if it was one of their children that
4 was shot in that building, and if they act that
5 way you won't have any, any problems working
6 out a quick resolution. But a sense of urgency
7 is important. But I am -- I am really
8 impressed with what I saw of the system
9 yesterday and, and your words about a sense of
10 urgency today. Thank you.

11 MS. HENRY: And I'm -- again I will share
12 that with the City. And again we, we certainly
13 understand that the City has different issues
14 that they, they're dealing with, but for us
15 it's about the security of the system that
16 we're building, because as important as
17 building that three-hundred-foot tower, and
18 make sure that the coverage is the best that it
19 can be, we also want to make sure that that
20 system is safe, and that we know what's
21 happening with that system twenty four/seven.

22 CHAIR: I don't think there's anything
23 that prevents us if somebody were to make a
24 motion and it was seconded and passed. I'd be
25 happy on behalf of the commission to send a

1 letter to Tamarac expressing this commission's
2 support for their cooperation with Broward
3 County. If there was a motion and it passed
4 I'd be happy to do that.

5 MR. SCHACHTER: I would certainly like to
6 make that motion, Chairman, that, that Tamarac
7 expedites this process as quickly as possible.
8 I think public safety depends on it.

9 SHER. JUDD: Second.

10 MR. PETTY: I'll second.

11 SHER. JUDD: I think it's appropriate for
12 --

13 CHAIR: Mr. Petty, second the motion. All
14 in favor?

15 (Aye.)

16 CHAIR: Any opposed same. Okay, said
17 motion passes, so we'll prepare a letter and
18 get it out as soon as possible to the City of
19 Tamarac expressing this commission's support
20 for them to work with Broward County and
21 expedite the process, and approve that tower's
22 placement.

23 MS. HENRY: Thank you.

24 CHAIR: All right, thank you. All right,
25 the next -- and, Ms. Henry, are you going to be

1 able to stick around for a little bit this
2 morning? Okay, so if anybody has any other
3 questions after the other presentations we'll
4 ask you to come back up then. Okay, thank you.

5 The next presentation this morning will be
6 on Coral Springs, and Chief Backer is here with
7 us. And it will be Coral Springs' opportunity
8 to present on the radio system from the Coral
9 Springs' perspective. Chief, welcome back.
10 Thank you for being here again.

11 DEP. CHIEF BACKER: Good morning, sir.
12 Thank you. Before I begin I would respectfully
13 ask for permission from my counterpart at the
14 Coral Springs Police Department, Deputy Chief
15 Brad McKeone who is in charge of operations,
16 the ability, or opportunity to come up and
17 speak for a couple of minutes to address the
18 commission.

19 CHAIR: Sure. Absolutely.

20 DEP. CHIEF BACKER: Thank you.

21 DEP. CHIEF MCKEONE: Good morning. All
22 right, good morning Sheriff Gualtieri and
23 members of the commission. I'm asking that you
24 allow me a few minutes this morning to make a
25 few brief comments on yesterday's

1 presentations, and some of the follow up
2 questions that came from members of this
3 commission. I was in the audience yesterday,
4 but I wasn't expecting to speak. Based on the
5 agenda and the, and the reference to what was
6 put down, I thought it would be inappropriate
7 or disruptive that I come up from the back of
8 the room and tried to interject into those
9 presentations.

10 As Deputy Chief mentioned I'm the
11 Operations Deputy Chief for the Coral Springs
12 Police Department, my name is Brad McKeone.
13 What that means for people who many not be
14 familiar with law enforcement, Shawn is the
15 Deputy Chief of the administrative side of the
16 house, which is our dispatch center, which is
17 why he presented yesterday. I have the
18 operations side, which is the patrol, criminal
19 investigations, kind of the, the guys out there
20 on the street for lack of a better term, if
21 that paints a better picture.

22 I believe my involvement on the day of
23 this tragic event, and the different
24 perspective that I have based on my assignment
25 will be able to provide some clarity to both

1 the commission and, and other people in the
2 room, and assist you in accomplishing your
3 overall goals. The first point that I wanted
4 to talk about was the regionalization. Sheriff
5 Gualtieri, the way you talk about it, Sheriff
6 Judd, the way you talk about it I love it, I
7 think it's a great idea. The vision that you
8 guys have, the idea of how the system should
9 work is where we need to get I believe, and I
10 believe that is something that this commission
11 can truly help us all with.

12 But with that being said we didn't join
13 that system back in 2013/2014, whatever it may
14 have been. And again, I wasn't really part of
15 that decision, but that doesn't mean I'm not
16 responsible for making the changes that, that
17 come with, and making any improvements. But I
18 want to make sure again that there is no
19 confusion about our position that we do not
20 disagree with the regionalization, it would
21 offer a number of advantages, but back in 2013
22 when we did that study ultimately, we did,
23 again we decided not to join, and that was
24 based on coverage and capacity issues.

25 Again, Sheriff Judd, you mentioned just a

1 few minutes ago the system, systems need to be
2 in place. County Administrator, Ms. Henry, I
3 think she just mentioned, and kind of
4 summarized all the points that I had, that the
5 system is not in place. That existed in 2013
6 it exist today, it'll exist next year. We need
7 to get through that. If we can get through
8 that I believe that's one of those, as she used
9 the cog in the wheel, I think that's one of
10 those factors that we need to, so we can move
11 forward and have this conversation to see if we
12 can join the regionalization communicate
13 center.

14 Not only would this having us join, would
15 have impacted negatively the City of Coral
16 Springs, it would have impacted the City of
17 Parkland, the City of Coconut Creek, the City
18 of Tamarac, because potentially we would have
19 overloaded their system, and they would have
20 also experienced issues, so it wasn't just the
21 citizens of Coral Springs, again, Sheriff Judd,
22 as you were kind of talking about that, that
23 global aspect, or looking at more than just the
24 local community, we had to consider things like
25 that, how would that negatively impact other

1 cities that we would be joining.

2 I have a study that I brought with me, I
3 think we mentioned yesterday. I can provide
4 that to the Commission. It kind of goes into
5 more detail. I don't want to take up too much
6 time going through some of that when it's
7 already documented, you'll have a chance to
8 look at it, or we can send it to you
9 electronically if you wish.

10 The radio, though, is not, and should not
11 be the only factor preventing us from
12 regionalization. The next area of concern is
13 the CAD. And this where again I'm going to
14 kind of go to the members of the commission and
15 Sheriff Gualtieri and ask for your assistance.
16 We've had discussion about switching over to
17 the CAD, but there's limitations that, that are
18 either imposed or expected for us to, to deal
19 with, and that has a negative impact on the
20 level of service that I can provide, that we
21 can provide to the residents of Coral Springs
22 and the residents of Parkland for fire service.

23 And again, it's not because it has to be
24 that way, that's the way that we want it to be,
25 or people want it to be, or, or the board may

1 want it to be, so again I'm asking for your
2 assistance. Just like the tower in Tamarac,
3 any influence, any type of ground that we can
4 gather in that way I think would be helpful to
5 all of us in, again, increasing public safety.

6 The second point that I just want to touch
7 on briefly was, was something that was
8 discussed yesterday about that hometown feel.
9 It -- I know it kind of -- I don't know if it
10 came across accurately, or it was presented in
11 the most, the most effective manner, the way
12 that we kind of envisioned it, but Deputy Chief
13 Backer's example, and I say the duck lady
14 because when I was a patrol officer that's how
15 I knew her, and that's how dispatch knew her,
16 she fed the ducks every morning so she was the
17 duck lady. The dispatchers, again, knew that.

18 When she went into that canal and she said
19 where she was, and she was there feeding the
20 ducks, nobody had to know the address. We knew
21 where to go. We knew the canal. We saved her
22 life. She may have died if that had not been
23 that knowledge that our dispatchers had, that
24 our officers had, that institutional knowledge.
25 I guess, you know, maybe a better way to say it

1 is the hometown knowledge of your city, and I
2 believe yesterday representatives from BSO even
3 acknowledged that at one point, that that is a
4 tremendous advantage to have that hometown
5 firsthand knowledge of the city that a
6 dispatcher or communications center operates
7 in, and knowing that if you say it's the upside
8 down building nobody in this room know what
9 that means. If you're a Coral Springs officer,
10 every dispatcher knows where the upside down
11 building is. That's again, those little
12 points, again I just wanted to maybe highlight
13 that briefly.

14 You know being able to adapt quickly and
15 efficiently has been a proven method by the
16 Coral Springs police and fire departments. The
17 report that I previously mentioned with regards
18 to the regionalization and the CAD restrictions
19 again has, has some impact on that. If there's
20 a negative impact to the citizens of Coral
21 Springs or Parkland with regard to fire
22 service, we must and always will put their
23 safety first.

24 And the last point I just want to touch on
25 briefly was, was to you, Mr. Schachter.

1 Yesterday you asked how many calls are
2 transferred to BSO. Based on my evaluation of
3 the law enforcement response, which I may be
4 back in front of this commission at another
5 time to present based on that when we get to
6 that point, but I can tell you that there was a
7 total of four calls that were transferred in
8 some way, shape, or form, to Broward County
9 communications. My understanding is that three
10 calls were transferred, and one call was put
11 out over what we call a mutual aid, channel, or
12 a fourteen-call channel which directly goes to
13 the Broward County Communications Center.

14 That first call that we received was
15 transferred within twenty-seven seconds. The
16 first call that was transferred regarded
17 information, or had information about an active
18 shooter at Douglas High School, that multiple
19 shots had been heard, and on the tapes you can
20 hear the shots, information about injuries, and
21 the location of the incident being the 1200
22 building. That information was provided within
23 twenty-seven seconds roughly to BSO.

24 And one last additional thing I'd like to
25 again to mention to you, Mr. Schachter, I would

1 like to say thank you, and I appreciate the
2 time that you have taken outside of, of this
3 commission to meet with us to facilitate some
4 of those meetings with the City of Parkland,
5 members of BSO. Because of your efforts we
6 truly had made a difference, and put things in
7 place that have made, allowed us to better
8 serve both Parkland and Coral Springs on the
9 police and fire side, so again thank you.

10 In closing I just wanted to again thank
11 you for allowing me the time to make these
12 comments. I know that it wasn't on the agenda.
13 I'll be here at the end of Deputy Chief
14 Backer's presentation which, you know,
15 regarding the radios I believe. And if there's
16 any follow up questions I'll be more than happy
17 to come back up and answer them at that time.

18 CHAIR: When's the last time you all had
19 active discussions with the County, or with BSO
20 and the regional communication center about
21 your differences in the CAD system? When's the
22 last time you all sat down at the table, had a
23 discussion, and tried to reconcile those
24 differences?

25 DEP. CHIEF MCKEONE: I'm going to speak

1 based on what I've been told, and correct me if
2 I'm wrong, but that, those conversations had
3 taken place very recently, especially after
4 this incident. And before that there was
5 conversations, but we've even looked into
6 options of, and I think you had mentioned, or
7 touched on it yesterday at some point, that
8 it's not that this has to be an all-in thing,
9 it doesn't have to be one way, there's options
10 out there whether we host servers, whether we
11 have licenses, and again I'm not a technical
12 person, but there are options.

13 And -- and this is again where I'm going
14 to come back to the commission and ask for your
15 assistance, sometimes -- there's a saying in
16 police work. The only things cops hate more
17 than change is for things to stay the same.
18 And with that, this is where we need to maybe
19 get out of that mindset, we need to be open to,
20 okay, there's a different way to do it, there's
21 a, maybe there's a better way to do it, I can
22 accomplish my goal, but maybe I have to do it,
23 I have to make a left instead of a right. And
24 that's where to your, to your point about the
25 CAD system, there are options, we, we need to

1 talk about those and figure it out.

2 CHAIR: So, Coral Springs is willing to
3 collaborate and compromise, and make every
4 effort to reach a consensus to make that
5 happen?

6 DEP. CHIEF MCKEONE: Absolutely. Look, I
7 think it's something that needs to take place
8 tomorrow.

9 CHAIR: And so, to that end as well,
10 because, you know, you raised it, so you talk
11 about the hometown feel, you know, I started my
12 law enforcement career working for a small city
13 police department, I get it, thirty-five
14 residents, thirty-five thousand residents in
15 the city. I was a city cop, I get it. We
16 contract with thirteen cities, I get it, but
17 there's also ways to make that happen as well
18 like we talked about yesterday, because the way
19 the system can work is, is you can be part of
20 that regional system for 911 so when somebody
21 calls the person they're talking to can get
22 them help and they don't have to be
23 transferred.

24 You can reach consensus on a CAD. There's
25 no reason why a CAD system, the data fields,

1 EMD, EPD, EFD, can't be worked through by
2 everybody, and you can still have that hometown
3 dispatcher employed by the Coral Springs Police
4 Department who is sitting up there in the front
5 of the room on that console that's talking to
6 the Coral Springs cops on the street. That
7 system works in other parts of Florida. It
8 works in other parts of the country. So, you
9 can still maintain that, and still have the
10 synergies and the efficiencies, and the
11 effectiveness, and the great service delivery
12 that all that brings and still maintain what
13 you're talking about.

14 DEP. CHIEF MCKEONE: And I couldn't agree
15 with you more. And again, that's back to what
16 I said before, the vision, and the way that
17 members of this commission with years and years
18 of experience in law enforcement speak about
19 that, that concept, and how it can work, that's
20 what we need to do. And maybe we, you know, on
21 all sides we need to be a little flexible. We
22 need to, to say, okay, I can live with that
23 because of the benefits that it provides. So,
24 I appreciate that.

25 CHAIR: And we'll -- we look forward to

1 doing everything we can to help you, and to
2 help Coral Springs, and to help everybody in
3 this community come together, and bring it
4 together so that the best safety services are
5 delivered to the citizens. And anything we can
6 do to help, let's all take that like Sheriff
7 Judd said, we're not here just to figure out
8 what happened, you know, we're spending a lot
9 of time and effort because we want to, and we
10 believe that there's an opportunity to make it
11 better, and to help you all get it to where
12 everybody wants it to be.

13 So, we certainly appreciate your comments,
14 and your time, and thank you for coming forth.
15 Do any other commission members have questions
16 for the Chief before we turn to over to Chief
17 Backer? Sheriff.

18 SHER. JUDD: I just want to congratulate
19 you and say that's professionalism.

20 DEP. CHIEF MCKEONE: Thank you.

21 SHER. JUDD: And there's nothing that I
22 would want more than for Broward County to be
23 the example as to how we should do it all
24 across the state, and all across the nation,
25 because the reality is if we can't create the

1 energy to create the best professional cohesive
2 system at ground zero in Broward County then
3 we'll never get it done any place else. And to
4 me when I hear you speak about, yes, we all
5 need to give a little, it needs to happen
6 tomorrow, and you all work toward that end
7 while this commission is working, that's
8 professionalism.

9 CHAIR: Go ahead, Mr. Schachter.

10 MR. SCHACHTER: I just wanted to say thank
11 you. Thank you for being transparent, thank
12 you for coming up here and talking to us, and
13 your commitment to fixing this. And I want to
14 tell you from my family thank you, and all the
15 Coral Springs residents.

16 DEP. CHIEF MCKEONE: Thank you.

17 CHAIR: Thank you. All right, Chief
18 Backer.

19 DEP. CHIEF MCKEONE: Sir, again, thank you
20 for the latitude with the schedule, and the
21 flexibility.

22 CHAIR: Absolutely.

23 DEP. CHIEF BACKER: I understand that I'm
24 here to talk about radio systems today,
25 specifically what Coral Springs has in place at

1 this time. And obviously we'll be addressing
2 the patching issue that is on the foremost of
3 everybody's mind that occurred on that day.

4 The first slide that I have here is just
5 providing a little bit of background. It goes
6 back to 2005, in which it dictates that P25
7 became and adapted technology, a pathway by the
8 Public Safety Institute. P25, for those that
9 don't understand, is basically a set of
10 standards for the design and manufacturer of
11 interoperability two-way radio systems. So,
12 that became the standard back in 2005.
13 Concurrently at that time in 2005 Coral Springs
14 radio system had already begun to reach end of
15 life. The City moved forward with trying to
16 procure digital P25 compliant radios in
17 anticipation of moving to a new radio platform.

18 In 2013, as Deputy Chief McKeone
19 maintained, I believe we spoke about yesterday,
20 the City had consulted with RCC Consultants to
21 evaluate not only our current environment and
22 our technology, but also all available options
23 to us. And I'm going to spend a little bit of
24 time on this slide because it goes back to
25 everything we've been discussing today about in

1 a perfect world if all the systems are in place
2 properly than a regional system could work, and
3 we'd really have no justification for not being
4 a part of that.

5 So, when RCC issued their recommendation
6 to us they had concerns over radio capacity and
7 coverage not being adequate back in 2013.
8 Those concerns still exist today in 2018, and
9 until the new system is up, 2019, 2020, that
10 concern is still in effect, and that does
11 affect the level of service, not only to Coral
12 Springs but some of the contiguous cities
13 around us, with the documented throttling
14 issues that have taken place.

15 RCC in their recommendation was also
16 concerned over the governance of the CAD. I
17 know we just addressed that again. And again,
18 this is where maybe some recommendations and
19 some influence from the commission will have a
20 beneficial impact going forward, for not only
21 us but the County, in that there has got be a I
22 guess a little bit of give and take, right?
23 Maybe we've got our heels dug in, and they've
24 got their heels dug in, and everybody has got
25 to sit back down and be a little bit for

1 flexible and accommodating to each other. And
2 we're hopeful that maybe with some of your
3 guys' influence that will take place.

4 Another byproduct of the report that was
5 issued by RCC was that our local government
6 radio users would not be able to transition
7 over to the regional system. That is a concern
8 for the City of Coral Springs. Our utilities,
9 I believe Parkland's utility department, our
10 parks and rec, they all inter-operate on that
11 local government system on our system now.

12 I want to take a moment and just, I know I
13 kind of just talked about it, but I want to
14 read from the actual slide that was presented
15 to our commission back when these decisions
16 were being made. And again, I want to
17 reiterate that a lot of these conditions are
18 still in effect today, which impacted our
19 decision to buy a new radio system.

20 Migration of the Broward County system not
21 recommended by RCC. It doesn't not provide
22 satisfactory in-building radio coverage within
23 the City of Coral Springs. At or nearing full
24 capacity, does not offer the same dedicated
25 channel capacity as provided by the City's

1 existing system. The County does not have the
2 capacity to support local government users.
3 The County's system coverage and channel
4 capacity can't be expanded until upgrade in
5 2018, which as we know is not going to happen
6 in 2018. Loss of direct control of talk groups
7 standards and maintenance. That's referring
8 back to the CAD and the governance.

9 So, all of those things were things that
10 were taken into account by the City when they
11 chose to not join the system. And again, going
12 back to a Utopian society, a perfect radio
13 system, perfect CAD, all that works great, and
14 everybody can join the regional system. But
15 the system has not performed satisfactory to,
16 to our best of our knowledge. In fact, if you
17 were to do just a basic Google search you would
18 come up with a litany of articles talking about
19 some of the performance issues that the system
20 as a whole has experienced. Those are a great
21 concern to the leaders of Coral Springs, and
22 the level of service that we're able to provide
23 to our constituents.

24 In fact, when you look at those articles,
25 I've personally, we've talked with Chiefs of

1 Police that are actually exploring the
2 possibility of getting out of the regional
3 system. I think that's the point that it's at
4 right now, from a level of frustration from
5 some of the end users. So, again, circling
6 back around, I just think it's going to be of
7 critical importance for this commission to have
8 some solid recommendations about how to avoid
9 those kind of circumstances, and how to
10 actually move this system forward to being
11 truly regional to provide the best service to
12 the County.

13 Okay, I'm going to get back on track to
14 the actual assessment and radio. Our old
15 system was a Motorola Legacy 800 trunked radio
16 system. I believe we heard a lot of testimony
17 yesterday about what that means and how that
18 operates. Key bullet let me see if the pointer
19 is working here, no. Key bullet, in 2005
20 critical components had reached end of life and
21 were no longer supported. I'm going to say
22 this, and it's going sound almost comical, and
23 when I heard it I couldn't believe it. We were
24 actually buying parts off of E-bay to keep the
25 radio system running, Motorola could not

1 provide parts, end of life, done, we had to
2 replace. So, again, when you look at the
3 totality of that, and the capacity issues, I
4 think the City almost felt obligated to move
5 forward with procuring their own radio system.

6 It's kind of what I just talked, touched
7 on there on that side. A key point here, again
8 the radio system that we brought is a hosted
9 master site radio system digital P25. It
10 provides complete interoperability through
11 patching with every radio system in the County
12 that exists today. In 2005 the City of Coral
13 Springs implemented their new radio system.
14 Sometime in May of that year we cut over to the
15 new radio system. In addition to the new radio
16 system all of the radio consoles in the
17 communications center were upgraded to the P25
18 standard as well. And one of key components,
19 and one of the things that was of extreme
20 importance to the City leadership, and is still
21 very important today, and, Senator Book, I
22 think you saw it when you came to do the tour,
23 by switching to the new radio, and then
24 ultimately to the CAD system that we procured,
25 our radios are GPS enables.

1 We have a screen right over our main
2 channel console that shows the City of Coral
3 Springs and where every police and fire unit is
4 at that moment. It's color coded to tell you
5 whether they're in route to a call, at a call,
6 available, so it provides us an ability to
7 provide closest unit dispatching and know where
8 everybody is in real time. If you were an
9 officer and you get in a foot chase through,
10 you know, a community, they can zoom into that
11 grid, or area where you are, and they're going
12 to know right where your radio is to be able to
13 provide support and get, you know, assistance
14 to you. So, that was a huge benefit for us,
15 and again part of the reason that some of the
16 decisions were made for the community of Coral
17 Springs.

18 A couple other technological pieces. When
19 the radio was upgraded there were six repeaters
20 that were installed for the fire department to
21 boost in building radio coverage. I'm not sure
22 if you've got any Walmarts -- or any -- some of
23 the labyrinth schools that exist that are these
24 concrete monoliths, even the best system you
25 can have some dead spots inside of something

1 like that. So, we did a study to look at that,
2 and we procured some repeaters to insure that
3 in coverage, building in coverage was
4 sufficient.

5 And yesterday we also heard, or during the
6 demonstration you heard about a microwave loop.
7 That is what our system has today. We have
8 three tower sites, one being in the confines of
9 the Coral Springs Police Department Public
10 Safety Complex in Coral Springs. We lease some
11 tower space in Margate on a cellular mobility
12 tower. And then the third place that we have a
13 tower with equipment is in Coconut Creek. That
14 tower is owned by the County. It is by their
15 good graces that we are allowed to have our
16 equipment co-located up there.

17 Okay, moving on to kind of the nuts and
18 bolts of what our radio system looks like on an
19 everyday, you know, every day activity, a
20 normal day. We have eighty-three talk groups,
21 and I think you guys heard some testimony
22 yesterday as to what a talk group is, any of
23 which can inter-operate with the regional
24 radio. Currently our radio system has one
25 thousand one hundred and thirty-four users on

1 it. That does include not only all of our
2 public safety but also all of our local
3 government users. And as noted before we would
4 have still had to maintain some level of a
5 radio system for the local government.

6 The system also includes the fire station
7 alerting system, which as I'm not a fireman I'm
8 not really proficient in what that, how that
9 operates or what that does. If you need to
10 hear more testimony on that I do have somebody
11 from fire here. Key point here, daily average
12 capacity usage of our radio system is between
13 eighteen and nineteen percent, okay, so
14 basically what that's telling you is that our
15 system is not overtaxed or doesn't have enough
16 capacity to handle. In fact, on February 14th
17 I don't believe we ever rose about forty-eight,
18 above forty eight percent capacity for our
19 radio usage, so we have plenty of capacity.

20 Our radio system has eleven channels and
21 since it's trunked, you heard how that works,
22 the controllers select which channel you're
23 going to get to transmit over. Of our eleven
24 hundred thirty-four users from a police
25 department standpoint what you're looking at is

1 two hundred twelve officers, is our allocated
2 strength right now, and we have about a hundred
3 civilian support staff. Not all of them are on
4 radio, some of them are clerical in the
5 building.

6 And the reason I bring up the manpower and
7 the staffing is to show you what our talk
8 groups look like. So, we have one main
9 channel. I know we call it a channel, it's a
10 talk group. We have our main channel. We have
11 a law teletype, which is where the officers
12 would switch to to run driver's license
13 inquiries, criminal histories, background
14 checks, get general information. We have two
15 tactical talk groups that can be used for
16 operations. And then we have sixteen
17 additional talk groups for special operations,
18 the SWAT team, the VIN unit, our VICE and
19 Narcotics unit, excuse me for the acronym.
20 They would have, you know, their own dedicated
21 and encrypted channel for usage.

22 Generally, on a day to day basis if you
23 were talking about patrol on, or excuse me, if
24 you were talking about BRAVO shift, which is
25 the daytime hours, our minimum staffing is

1 fifteen officers. You're going to have
2 probably two sergeants and a lieutenant.
3 You're going to have a litany of detectives,
4 traffic units, specialty units, special
5 operations officers, or excuse me, detectives
6 that are going to be out there on a day to day
7 basis, so a fair average number.

8 You're looking at about sixty users just
9 on the police side at any one given day during
10 the week. Those numbers are a little bit less
11 on the weekend, as some guys are off during the
12 weekend. ALPHA shift again is probably going
13 to be about half those users when you look at
14 the patrol minimums, and not all of the
15 specialty units working at night.

16 Our fire department that services Coral
17 Springs and Parkland has a main channel talk
18 group. They have five tactical talk groups and
19 six additional talk groups for special
20 operations or training. Their radio coverage
21 includes eight fire stations, the fire
22 administration and inspections division, and
23 equates to roughly fifty users a day again on
24 that same radio system.

25 The last component to the users that are

1 on our radio system would be the local
2 government users, and that adds roughly about
3 another ninety, so doing rough math, you know,
4 we're closing in on about two hundred users
5 during the week during the day that are on the
6 system at any one time.

7 This is a quick chart to just show you the
8 basic push to talk usage that our radio
9 experiences. This chart is from February 14th.
10 It does show you the spike during the time
11 frame in which we were responding to Marjory
12 Stoneman Douglas. And this is an important map
13 in my opinion. This map, what's outlined in
14 the dark black shows Coral Springs, but the
15 green shaded area is the coverage map that our
16 radio provides. So, in the event that somebody
17 else is on a different radio system, and
18 they're within a lot of miles of us,
19 geographically we have the ability to patch and
20 provide a redundant level of service that might
21 be lost otherwise.

22 All right, patching. I know this came up
23 yesterday. I'm sure there's some questions
24 that everybody has. I'm going to talk through
25 the slide, and then I'd like to talk about a

1 few operational components to that if I could.
2 A patch group, I think you guys all understand,
3 is a link to talk groups that allow radio users
4 to communicate with each other while on
5 separate radio systems. I like to describe a
6 patch as basically kind of a three-way call.

7 When radios are patched theoretically
8 everybody that's on both systems can hear
9 everything that's taking place and transmit
10 across both systems. On February 14th there
11 were a lot of patching, or patching situations
12 that occurred. Within our own communications
13 center our fire department patched three
14 channels together for them to support their
15 operations. Typically, the host agency does
16 the patch.

17 And why do we patch? Let me, before we
18 get into the mechanics of what took place that
19 day. I've explained this before in other
20 areas, and I want to explain it again. I think
21 the Sheriff started demonstrating when you take
22 a radio out. When this call goes out you have
23 officers from all these agencies driving what
24 we call code three, lights and sirens, very
25 fast through rush hour traffic thinking about

1 do they have their vest on, getting their rifle
2 out, where do we park, what's going on. The
3 stress is incredible.

4 When stress takes over the first thing
5 that goes is fine motor skills, okay? It is
6 not a practical exercise, in my opinion, to ask
7 an officer to pull their radio out and start
8 manipulating some of these small buttons, if
9 they even know where the other agency's channel
10 is on the fleet map within the radio. That's
11 why patching for as far back as I can remember
12 has been basically the practice down here in
13 South Florida, because it is a more effective
14 efficient way.

15 The other thing about patching versus
16 switching radio channels, take the 14th for
17 example, we had a hundred and thirty, or a
18 hundred and thirty-two officers that went. I
19 have to be able to ensure that all hundred
20 thirty-two officers heard where to go, know
21 where it is, and then somehow some way you'd
22 like to be able to confirm that they're over
23 there so that we know we have everybody on
24 board and accounted for. That's not practical,
25 doing it, that's why patching has been the

1 industry standard. And I'm trying to explain
2 that in lay terms, you know, that's why
3 patching has been kind of the industry
4 standard.

5 So, on the 14th, typically what happens,
6 the agency that's responsible for the response
7 is typically what's called the host agency for
8 the patch, meaning they effect the patch, okay?
9 What I can tell you in reviewing the
10 information is that we were calling the
11 Sheriff's Office at the same time they were
12 calling us to discuss the patch, and ultimately
13 what was communicated to our dispatch center
14 was that BSO did not have our main channel on
15 their console, and they were asking us to patch
16 the radios. And they specifically asked for us
17 to patch 13JOINTOPS2.

18 I don't know why that decision was made
19 versus 8ALPHA. I don't know. I can't answer
20 that. But what I can tell you is that after
21 that request was made our dispatchers were able
22 to effect the patch, and according to the
23 analytics that we've received from Motorola
24 that patch stayed up for six hours and nineteen
25 minutes, okay? Now I'm going to talk about

1 that for a second, because we're not a hundred
2 percent convinced that is entirely accurate.
3 The patch was up. We're not sure everybody
4 could hear.

5 We do have a couple moments on the radio
6 where it appears that possibly certain officers
7 couldn't hear what was transpiring. I don't
8 know if that's user error, or a failure of the
9 patch. That's something that has to be
10 analyzed. It's something that the County is
11 aware of. We were told after this event at a
12 meeting that the County was aware. I think BSO
13 and us had brought this concern forward, and
14 the response that we got from the County was
15 that this was something that the police
16 foundation who is conducting their after action
17 would be looking into.

18 We were concerned what that delay would be
19 and having the information or answers to that
20 would be way too long, so we did author an
21 e-mail to the County asking for that
22 investigation to be expedited. So, we're
23 hoping to get some answers as to -- I'm sorry?
24 No, I never received a response back. So, in
25 regards to Broward Sheriff's Office not having

1 our main channel on their console, when I heard
2 that, somewhere around April 3rd that was
3 brought to my attention. I was kind of stunned
4 to be honest with you. I've heard their
5 deputies come up over our radio, so I know
6 their deputies have us in their radios. I had
7 no idea that we were not programmed into their
8 main channel console.

9 I immediately told Kathy Liriano that we
10 would authorize that. We received a
11 communication from them asking for the
12 authorization. The next day Chief Perry signed
13 a letter authorizing them to program our main
14 channel, or multiple frequencies, let me see,
15 it looks like four, definitely two, our PD main
16 and our patrol tactical channel were provided
17 to them. April 4th we gave them authorization
18 to program those channels into their consoles.
19 And again, we had no idea that we weren't in
20 their console.

21 Depending on the population right now
22 Coral Springs is somewhere between the fourth
23 and fifth largest city in Broward County, so
24 the fact that we wouldn't be on their system
25 wouldn't even seem obvious to us. It would

1 seem obvious that we would be. But I'm glad to
2 say that I think that's been rectified now
3 moving forward.

4 I have a couple other slides pertaining to
5 patching, but they're more illustrative in
6 nature. Yesterday you saw some very similar
7 slides during some of the other presentations,
8 and this is what our dispatchers see in regards
9 to patching, their console for patching. And
10 as I've described, and as we demonstrated for
11 Senator Book, it's roughly three to four clicks
12 of a mouse to be able to link a couple channels
13 together. So, this is one of the two screens
14 that shows all of the consoles that are
15 available for our dispatchers to select. And
16 then this is some of the nomenclature that is,
17 if you look back to the previous screen, the
18 top right, that's the area where the patches
19 are effected.

20 I can't speak to the technical terms, I'll
21 talk in layman. That's the box where all the
22 patches get dumped into and executed, and then
23 these are just blow ups of what those patches
24 look like, and you can see that we are able to
25 effect more than one patch. And this shows

1 you, the box on the right shows you that once
2 the patches, or once the talk groups are in
3 there and the execute button is hit, it shows
4 you that the channels are patched. In layman's
5 terms, for the best I can do to explain that.

6 All right, with that I will make myself or
7 Deputy Chief McKeone available for any
8 questions.

9 CHAIR: While you're right there go back
10 for a second to what you just said about April
11 3rd.

12 DEP. CHIEF BACKER: I'm sorry?

13 CHAIR: Go back to what you just said
14 about April 3rd. You said April 3rd, correct,
15 I want to make sure I get this date right.

16 DEP. CHIEF BACKER: Yes, April 3rd.

17 CHAIR: You said on April 3rd of 2018 you
18 became aware that Broward County Sheriff's
19 Office did not have your main channel in their
20 console, right?

21 DEP. CHIEF BACKER: Yes, sir, we received
22 an e-mail from Broward County requesting those.

23 CHAIR: So -- and then you mentioned
24 previously that on February 14th that -- and
25 Broward County testified yesterday that they

1 could not affect the patch on February 14th
2 because they did not have the Coral Springs
3 main channel, correct, that they didn't have it
4 in their console to patch. They're the host
5 agency, so they're responsible for doing the
6 patch. They -- they theoretically could have,
7 should have, best case scenario, patched 8A
8 with the Coral Springs main talk group, right?

9 DEP. CHIEF BACKER: In an ideal situation
10 that's what would have taken place.

11 CHAIR: Right.

12 DEP. CHIEF BACKER: I didn't hear the
13 testimony yesterday, but I have reviewed the
14 call in which their duty officer called us and
15 indicated that they didn't have us in the
16 console.

17 CHAIR: Right. So, Ms. Mize testified
18 yesterday that they couldn't effect the patch
19 because on February 14th they didn't have your
20 channel to patch. You can't patch what you
21 don't have, in essence, okay. So, then you
22 just testified that there was a request though
23 for -- so my question -- on the February 14th
24 did Coral Springs in its console have 8A in its
25 console?

1 DEP. CHIEF BACKER: I believe so, but I'd
2 like to check without communications
3 administrator.

4 CHAIR: She's saying yes. Okay, so --

5 DEP. CHIEF BACKER: That's a yes.

6 CHAIR: Right. So -- so you said though
7 that somebody for some reason requested that
8 the patch be a 14JOINTOPS2 as opposed to the
9 patch -- so in other words as opposed to --
10 Broward County Sheriff's Office under the
11 protocol here in Broward County is the host
12 agency, was responsible for the patch under the
13 established protocol, correct?

14 DEP. CHIEF BACKER: Yes, sir.

15 CHAIR: Okay. But they couldn't effect
16 the patch because you can't patch what you
17 don't have. So, somewhere, if I understand
18 this is, is that what would have been a better
19 course was for somebody to say, okay, we can't
20 do this, but Coral Springs, you have obviously
21 your main channel, and you have 8A, so Coral
22 Springs, you guys go ahead and effect the patch
23 of 8A with the Coral Springs main, and you
24 effect the patch, but as opposed to doing that
25 somebody said patch 14JOINTOP2 that nobody was

1 on.

2 DEP. CHIEF BACKER: I don't know who from
3 the County would have --

4 CHAIR: But is that what you're saying? I
5 want to make sure I understand what you're
6 laying out for us.

7 DEP. CHIEF BACKER: Right. The phone call
8 that we received in our communications center
9 from their duty officer --

10 CHAIR: I think Kathy knows.

11 MS. LIRIANO: Good morning commission.
12 Chair, so on the 14th, on February 14th we
13 were, we received a call from a duty officer
14 from the Broward Sheriff's Office. On that
15 call they advised that they did not have Coral
16 Springs Police main channel on their consoles,
17 and they requested for Coral Springs to patch
18 to 140PS2. We did on that day. And prior to
19 this incident since the upgrade of the radio
20 system have all of Broward County's main
21 channels for every district on our consoles,
22 including the mutual aid channels.

23 CHAIR: And -- and is there any reason --
24 so you did patch 14JOINTOPS2, you did patch it.

25 MS. LIRIANO: Yes, sir.

1 CHAIR: Okay. So is there any reason, you
2 know, why somebody didn't say to the Broward
3 duty officer, look, we can patch it, but you
4 guys can't, we need to stay on the primary, as
5 like the Chief laid out for tactical reasons
6 and operational reasons, is that why don't we
7 just go ahead and patch 8A as opposed to doing
8 what they said, or what they asked, and doing
9 what would have been more effective
10 operationally? Did anybody -- is it because
11 nobody just thought about it, or why, why
12 didn't you guys just do despite of what they
13 asked, is my question, if you know.

14 MS. LIRIANO: No, when the -- in a normal
15 -- in a perfect world, host agencies do the
16 patch.

17 CHAIR: Right. Right.

18 MS. LIRIANO: And at that point they
19 didn't have our --

20 CHAIR: Right, but what I'm saying is, and
21 I know they didn't have it, right, I know they
22 didn't have it, but why didn't -- knowing that
23 they didn't have it why didn't you guys just do
24 it because you had both?

25 DEP. CHIEF BACKER: I'm going to give you

1 my opinion, or my assumption. If I were
2 receiving that call and that was the request
3 that was made of me I would assume that they
4 had already moved their operations to that
5 channel, and that's why they were patching us
6 together with that channel.

7 CHAIR: No, fair enough. I'm just trying
8 to figure it out so that we understand. And
9 there may not be an answer to it.

10 DEP. CHIEF BACKER: I think -- quite
11 frankly I think the Broward Sheriff's will have
12 to speak to why that request was made for that
13 particular channel.

14 CHAIR: And -- and we can ask them. It
15 may have just been some person who just --

16 DEP. CHIEF BACKER: Thinking in the heat
17 of the moment.

18 CHAIR: Right. I get it. I get it. But
19 -- but if, and again in that perfect world we
20 don't live in, if, because they didn't have it,
21 if you all had, again this is not a casting of
22 anything, but in that, again in that perfect
23 world that doesn't exist, if somebody said,
24 hey, patch 14JOINTOPS2, and somebody on your
25 end had said, you know, you sure, because

1 nobody is on that, why don't we just go ahead
2 and patch 8A with us, then hypothetically that
3 would have been a -- not even hypothetical,
4 that would have been a better course. But
5 again, that's the perfect world that doesn't
6 exist.

7 DEP. CHIEF BACKER: I think knowing what
8 we know now I hundred percent agree with that.

9 CHAIR: Yeah. Right. Okay. Okay, I just
10 want to make sure we understand, and we know
11 the landscape. All right, commissioners,
12 questions? Sheriff Ashley.

13 SHER. ASHLEY: Thank you, Chief. Yes,
14 sir. If I'm a Coral Springs police officer and
15 I need to speak to Broward Sheriff's Office
16 from my portable am I capable of doing that?

17 DEP. CHIEF BACKER: Yes, sir, we have
18 their channels in here. You just have to know
19 where in the fleet map to switch to what zone
20 and what channel.

21 SHER. ASHLEY: So, would a Coral Springs
22 officer that day in Parkland be able to turn
23 his radio on and speak to Broward SO?

24 DEP. CHIEF BACKER: If they knew where to
25 manipulate the channel and the selector

1 switches to on the fleet map, yes.

2 SHER. ASHLEY: Would they normally know
3 how to do that?

4 DEP. CHIEF BACKER: I don't know how to do
5 it. I mean I know it's on there, but I'd have
6 to search.

7 SHER. ASHLEY: I guess that would apply to
8 if they needed to speak to a trooper they would
9 have to change the channel on their portable.
10 And do you know if they know how to do that?

11 DEP. CHIEF BACKER: They all know how to
12 do it, it's a question of knowing where
13 everything is in that fleet map.

14 SHER. ASHLEY: Okay. You said that your
15 radio system only had a forty eight percent
16 capacity on the day of the tragedy, is that
17 correct?

18 DEP. CHIEF BACKER: On the day of the
19 tragedy we never eclipsed forty eight percent
20 capacity of usage of the radio.

21 SHER. ASHLEY: Because nobody could talk
22 to you, wouldn't that be a fair assumption,
23 other than you're officers?

24 DEP. CHIEF BACKER: No, when the radios
25 were patched we were still at only forty eight

1 percent.

2 SHER. ASHLEY: How long does the patch
3 take? How long did it take to effect the
4 patch?

5 DEP. CHIEF BACKER: Once the request is
6 made, I believe it was up in under a minute.

7 SHER. ASHLEY: How long before the request
8 was made?

9 DEP. CHIEF BACKER: I'd have to go back
10 and look at the timeline of all that.

11 SHER. ASHLEY: I'm just trying to
12 determine was, was the tragedy done, was it
13 over when the patch was made? I mean we're
14 talking about six minutes here.

15 DEP. CHIEF BACKER: I would believe so,
16 because we were already on scene asking for
17 that patch, and the shooting was already over.

18 SHER. ASHLEY: Okay, thank you.

19 CHAIR: Kathy, is there anything you want
20 to add to clarify on that?

21 MS. LIRIANO: Just a couple of things.
22 When the radio capacity, when you're asking
23 about the forty eight percent, for those that
24 don't understand the radio system when, for
25 example, because it also included the fire

1 department, so with their three patches for all
2 the mutual aid that was coming in we had, you
3 know, every city in the County coming in
4 assisting us, their radios go onto your radio
5 system once you have that patch. The same
6 thing with law enforcement with that patch, so
7 when it reached the forty eight percent, day to
8 day eighteen to nineteen percent, having these
9 other agencies with these patches on our radio
10 system, it would load your system, and that's
11 why we reached forty eight percent.

12 SHER. ASHLEY: Thank you. And I guess --
13 and this is not directed at anybody. I guess
14 what I'm trying to identify for the commission
15 is we're talking about host incident
16 communications. I'm trying -- this commission
17 is trying to figure out how do we communicate
18 prior to and during this, and not after
19 everything has occurred, so patches are, are
20 not a fix here, it's over. And so, if the
21 Coral Springs can't communicate with Broward
22 Sheriff's Office when they're both responding
23 to the same scene then, then a patch doesn't
24 really help in trying to mitigate --

25 MS. LIRIANO: And just -- and I

1 understand, Commissioner. And one of the
2 things to under, to understand about talk
3 groups, let's say we were on the County system.
4 If we were on the County system and Coral
5 Springs had to respond, we would be on
6 different radio channels, or different talk
7 groups, so those talk groups would still need
8 to be patched for us to be able to communicate.
9 When the patch is initiated, obviously that
10 would be I guess a concern that you have, but
11 even in Broward County they have different
12 districts, different main channels that they
13 have to patch if they want their people to hear
14 unless they switch over.

15 SHER. ASHLEY: If I may just give an
16 example of our county. If one of our deputies
17 is at a scene, or at an incident, or responding
18 to, as back up to one of the municipalities in
19 our, in our county, they just turn to the
20 channel of the county, or the municipality
21 they're responding to. All those
22 municipalities are programmed in the deputy's
23 radio. He just turns a channel and he's
24 talking with their primary station at that
25 point. So, I just -- I'm just trying to figure

1 out that immediate communications, what's
2 necessary, and the patch doesn't fix the
3 problem that we're dealing with here.

4 DEP. CHIEF BACKER: Sheriff, on a day to
5 day basis here in Broward, with the geography
6 being what it is, we generally back up our own
7 officers, so the geography I think is a little
8 bit different, and not applicable here in this
9 environment, and I think that needs to be
10 considered as well. But I understand your
11 point.

12 SHER. ASHLEY: But you're backing up other
13 officers as well.

14 DEP. CHIEF BACKER: In Coral Springs.

15 SHER. ASHLEY: I mean Broward County
16 Sheriff's Office operates in your jurisdiction
17 sometimes. FHP operates in your jurisdiction
18 sometimes. I mean all these other law
19 enforcement agencies operate within your
20 jurisdiction, and might call for help, or try
21 to call for help, and being able to communicate
22 I think is certainly necessary.

23 MS. LIRIANO: And just so you are aware,
24 just like the Chief said earlier during his
25 presentation the officers, we have talked to

1 them on our main channel before, for Broward
2 Sheriff's Office, and also other jurisdictions,
3 neighboring jurisdictions that have our
4 channels that are under the regional system,
5 and they come over. If they're on a traffic
6 stop, or anything like that, they come over our
7 main channel. And a lot of the officers in our
8 city that work the north end, which is, you
9 know, adjacent to Parkland, they know how to
10 get over to their system, and where to locate
11 it.

12 SHER. ASHLEY: Was there any attempt by
13 Broward deputies on the scene to go to your
14 system, to your primary?

15 MS. LIRIANO: When -- when I was -- we
16 don't -- for when it comes to what their
17 officers did on that day we would have to
18 analyze -- and I have a report, I just have to,
19 you know, I'm not going to give you
20 misinformation of the radio activity, of who
21 was affiliated to our radio system. I know
22 that we had affiliations with Margate units,
23 but I know that as well we had a lot of fire
24 response, so I would have to compartmentalize
25 it between fire and police to be able to give

1 you the statement.

2 SHER. ASHLEY: Did any Coral Springs
3 police officers go to Broward channel that
4 you're aware of?

5 MS. LIRIANO: I can't answer that because
6 I don't have, I don't have a report to be able
7 to access their system.

8 DEP. CHIEF BACKER: I think that's
9 something that Deputy Chief McKeone when we get
10 into the response phase will be able to speak
11 on in that regard. I can tell us as someone
12 that responded myself I had no thought about
13 trying to get on my radio and switching
14 channels. To me in my mind it was always about
15 patching to them, and also being in contact,
16 and in communication with them upon arrival.

17 SHER. ASHLEY: Thank you.

18 CHAIR: I can tell you, Sheriff Ashley,
19 just in discussions we've had with BSO, and
20 with others is, is that most of the street
21 level personnel, while they've technically
22 somewhere in the fleet map had the capacity
23 most of them didn't know how to do it, and
24 don't know where those channels are, which then
25 raises a question about training. You know we

1 train in a lot of things, and we train in
2 tactical response, et cetera, but it raises a
3 question that has been brought up, is, is that
4 how often have agencies trained in radio
5 interoperability, and being able to move so
6 that you know, and do they have easy access.

7 One of the things that was -- and again,
8 because we know there's no perfection in this,
9 but one of the things that was -- I don't --
10 you probably didn't hear it yesterday, but one
11 of the things that was raised yesterday, and
12 Ms. Mize talked about it is, is that how the
13 zones are set up, right, A, B, C, D, et cetera,
14 and then you've got your talk groups within the
15 zones. In each zone, A, B, C and D, you can
16 have unique talk groups in positions, you know,
17 whatever, 1, 2, 3, 4, but some of the bottom
18 end ones are consistent across all the zones.

19 So, if it was set up where in every zone
20 the very last thing, and, Chief, your point it
21 well taken tactically speaking, but it is also
22 very easy. If you're in whatever position
23 you're in and all you got to do is turn it all
24 the way to the end and then everybody is on the
25 same page, that is a viable solution. But then

1 you come back to the issue tactically is, is
2 that if everybody was on one and you're
3 switching everybody over to the other, then
4 you'd have to do some sort of a board check and
5 make sure that everybody has moved to the end.

6 So, there -- there is no hundred percent
7 in, in any of this, it's a community, and it's
8 a law enforcement community working together
9 collaboratively trying to figure out how you
10 are going to effect the best interoperability
11 you can in these unique situations. And that's
12 probably where there's room, there's room in
13 our county, I can tell you that, and there's
14 room across the board. And hopefully this is
15 a, a learning point for everybody, is that we
16 need to do a better job with tactical
17 interoperability for these major events.

18 SHER. ASHLEY: One last -- separate
19 channels aside, certainly if everybody is
20 looking at the same CAD screen that would, that
21 information would be helpful as well. Thank
22 you.

23 DEP. CHIEF BACKER: I agree that seeing
24 that information at the same time would be
25 appropriate. Not everybody that's operating in

1 the city is running a CAD. For example, I have
2 no computer in my car. I would not expect an
3 officer who is driving well above the speed
4 limit negotiating intersections and dangerous
5 traffic to be looking at their CAD. I don't
6 think that that -- in fact our policy prohibits
7 that. It's not what we would want them to do.

8 But to your point, Sheriff, if I could go
9 back for a second, and I believe Sheriff Judd
10 said it earlier, those first few minutes, you
11 know, they're chaos. We're trying to get all
12 those things, you know, situation and under
13 control, and coordinated. Even if this had
14 just been solely a Coral Springs response, or
15 just solely a Broward Sheriff's response, I
16 think when you look at it those first few
17 minutes are just, they're a mess. There's no
18 other way to put it. You have so many
19 resources coming at one time, you know, and
20 everybody wants to, to help.

21 CHAIR: Sheriff Judd, and then Chief
22 Lystad.

23 SHER. JUDD: I think -- just so I have it
24 clear, the system and the process failed in, in
25 the sense that when you went to a new system

1 nobody went through a checklist to make sure
2 that regional had all, had your main, and had
3 all of your systems, right, I mean is that the
4 bottom line to it? Somebody -- someone some
5 place, either from your, from your radio group
6 to your systems administrator should have had a
7 checklist and said, okay, BSO has all of these
8 mains, or all of these systems in place, and in
9 fact as on go day they didn't have it.

10 DEP. CHIEF BACKER: Yes, sir, that's fair
11 to say. I believe the responsibility is within
12 each agency to inquire and get the
13 authorization to put whoever they want on their
14 console. I believe we've had them --

15 SHER. JUDD: But -- but the reality is
16 you're the one that changed the system. I mean
17 the administrator at regional, and I'm not
18 trying to defend regional, they wouldn't know
19 necessarily that you changed, or you changed
20 systems, or maybe they would, but it seems like
21 to me that the agency going to the new radio
22 system has the obligation to coordinate with
23 regional and go, hey, we got a new system here,
24 we need to get all this stuff programmed so
25 that we can all talk, and that just didn't

1 happen.

2 DEP. CHIEF BACKER: It did to some extent,
3 sir, because they have, the deputies all have
4 our radios programmed with the new radio
5 channels, so the frequencies were provided when
6 we upgraded. What they chose to program to
7 what of their equipment --

8 SHER. JUDD: So, they had your main, they
9 just didn't have it in the system.

10 DEP. CHIEF BACKER: That's my
11 understanding.

12 MS. LIRIANO: They didn't have it in their
13 console. So, customarily when we upgrade, for
14 any agency that upgrades the radio system there
15 is a letter that goes out to the counties, and
16 also, we also have an agreement with Palm Beach
17 and Miami-Dade, for letting them know,
18 informing them we are upgrading to this radio
19 system, and that's when the requests come in,
20 because, you know, there's a -- Plantation has
21 ours, they requested it. When they upgraded to
22 the P25 they also said, hey, we're upgrading,
23 you know, sent out the request to get our
24 radios onto your channel, onto your consoles,
25 and that's what we did.

1 CHAIR: But, Kathy, on the 14th if they
2 had, if the BSO deputies in their portables had
3 your channel, and your officers had your
4 channel in their radios, and the BSO deputies
5 had switched over to Coral Springs, and
6 assuming they knew, most of them didn't so they
7 couldn't get there, but assuming that they knew
8 and they could have got onto the Coral Springs
9 main channel, then they wouldn't have been able
10 to communicate with their dispatch because
11 their dispatch didn't have it in their
12 consoles.

13 So, by suggesting that the deputies
14 navigate away from their 8A and onto the Coral
15 Springs channel, then they would have no
16 communicate with their life link, which is
17 their dispatcher. So, it's -- that's a mess.

18 MS. LIRIANO: Yes.

19 DEP. CHIEF BACKER: Under operational
20 circumstances like that -- under operational
21 circumstances like that I think the prudent and
22 most effective way is to effect the patch.

23 CHAIR: Right, I get it. I get it.

24 SHER. JUDD: But at the end of the day
25 when you change that system you have an

1 ethical, not legally, an ethical obligation not
2 only to send a letter to them, but you should
3 have a check and balance system, so you go,
4 huh, I sent that letter a week ago and nobody
5 has contacted me back to make sure that this
6 stuff is on their main, or that they have
7 rejected the need for it being on their main.
8 So, had this data gone out, whether it's Palm
9 Beach, Miami, regional in Broward, wherever,
10 had this letter gone out, and if you said it
11 did I have no reason to doubt that, but if you
12 floated that letter out without any follow up
13 system and process in place then you're
14 gambling that in whatever is going on in their
15 world that that letter got to wherever it
16 needed to go to make sure that data was in
17 their computer.

18 So, there should have been a check and
19 balance. There should have been a follow up.
20 There should have been a tickler file on that
21 process to go, hey, we changed to a new system,
22 I floated this letter out, I hadn't heard a
23 word back. That's -- that's my point.

24 DEP. CHIEF BACKER: I see your point,
25 Sheriff, and I think that's something we can

1 most certainly look to implement going forward
2 as a process improvement, but I do know that
3 the fact that we were changing, and what those
4 new frequency were, frequencies were going to
5 be, was communicated. But to your point, yeah,
6 probably a better idea that we get together
7 during one of the, you know, monthly, you know,
8 regional communication meetings and have a
9 discussion about, okay, what was the impact,
10 what did you do, you know are we good to go,
11 you know, a hundred percent.

12 SHER. JUDD: Did you get us in your
13 system, did, okay, yes, I did, well, good,
14 let's have a check, what time are we going to
15 get together and check to make sure the system
16 works, because we know in our worlds, and, and
17 I suggest in everybody's worlds, but we just
18 know about ours, we're all very busy, and
19 sometimes paper and e-mails, and notes get
20 either discarded, not seen, shuffled off until
21 I get some time, and then they get stacked up,
22 and the next thing you know you end up with
23 this, this end result. You notified them, for
24 whatever reason it wasn't in the system
25 apparently.

1 CHAIR: Chief Lystad, you're next.

2 CHIEF LYSTAD: Thank you, Mr. Chair. Some
3 of the questions you already asked I was going
4 to ask, but I have a couple of other questions.
5 I want to start first with, with Coral Springs'
6 radio system, the current system, and its
7 capabilities. Have you seen the Broward system
8 that's supposed to come in place and online, do
9 you know the technical specs of that?

10 DEP. CHIEF BACKER: I do not.

11 CHIEF LYSTAD: You're nodding.

12 DEP. CHIEF BACKER: Kathy does.

13 CHIEF LYSTAD: Okay, so my question is, is
14 this. With the new system, one, is your radio,
15 or are your radios compatible, and able to
16 integrate into that system? That's my first
17 question. My second question is, is by doing
18 that would you lose any of the features and
19 benefits that you currently have with your
20 system?

21 DEP. CHIEF BACKER: So, you have two-part
22 questions. I can definitely answer the first.
23 In regards to the loss of features I think I
24 would have to turn that over to Kathy. My
25 understanding of the new system that they're

1 getting will be interoperable with us, but it
2 will require what's known as an ISSI link. So,
3 it is capable. I guess they're moving away
4 from a hosted master site system, they're going
5 to something different, and it's going to
6 require a link, but they will be interoperable.

7 In regards to loss of features, I'm
8 assuming you're asking about like the GPS thing
9 that I was talking about.

10 CHIEF LYSTAD: That's correct.

11 DEP. CHIEF BACKER: If we were to migrate
12 to their system I don't know what the GPS
13 capabilities are. I think --

14 MS. LIRIANO: So, basically, when the new
15 system that the County has procured, it is a
16 P25 compatible system. Currently with their
17 system Coral Springs and Plantation, we're all
18 under the Motorola hosted master site, so the
19 interoperability is, is effective. And ISSI
20 link that the Chief was explaining is that when
21 the County migrates to the new radio system
22 they're going to be maintaining their own
23 master site, but they still have a link through
24 the main hosted master site of Motorola so that
25 any other P25 compatible radio, or any radio

1 system through Motorola is able to still
2 communicate and have interoperability.

3 The feature of the GPS, it is a per
4 agency, from the meetings that I've attended
5 for the regional system it's per agency, if
6 they want to incur the costs of adding that
7 feature they can onto their radios, just like
8 we did, we incurred the cost of adding the GPS
9 feature when we established that policy.

10 CHIEF LYSTAD: Okay, so then the root of
11 the question becomes if you all consolidate, if
12 you all are integrated, so you foresee the same
13 difficulties that occurred during the Marjory
14 Stoneman Douglas response still being able to
15 occur and happen under the current, or under
16 the planned two systems coming together?

17 DEP. CHIEF BACKER: If all of the
18 components of the systems are working as
19 designed, and as they're supposed to, I believe
20 the response would be more effective, yes.

21 CHIEF LYSTAD: More effective, or it would
22 still have issues?

23 DEP. CHIEF BACKER: Well, when you have
24 two jurisdictions that are responding to one
25 event, again going back to those first couple

1 minutes, I think you're still going to have
2 that level of chaos, and until we get, you
3 know, face to face, and the radio channels
4 patched to be establish that command and
5 control, and start taking control of the scene
6 and giving out assignments, those first couple
7 minutes I still think are going to be rough.

8 CHIEF LYSTAD: Okay. The fleet map that
9 you have, is that designed by Coral Springs,
10 you design your own fleet map?

11 MS. LIRIANO: We did -- for police we did
12 design our own fleet map, and right now for, I
13 can give you a couple examples, for fire they
14 have a county fleet map, and right now we've
15 been in communication, I've been attending the
16 regional meetings, and law enforcement after
17 this incident, and also after the Fort
18 Lauderdale shooting, has said, look, they're,
19 they have something in place, fire does, we
20 need to adapt to the same. So, we are involved
21 in these meetings to try to do something as
22 similar as possible with them, the same layout.

23 One of the ideas that the Sheriff brought
24 up as the last channel, that Angela Mize had
25 brought up yesterday, so we are actively in

1 these meetings to work alongside the regional
2 system, because when they go to the P25 and
3 they're able, or have the capacity to add us
4 onto their consoles at the dispatch center,
5 which would be the, the best option, they can,
6 you know, just, all it is the volume to hear
7 what is going across. So, even if you're on
8 separate, different radio systems to have the
9 redundancy in case something were to happen to
10 the other, we are still, as long as you have
11 that talk group, the talk group is the key, set
12 up in your console, you're able to still
13 communicate with the other agencies, it's just
14 having the talk group set up onto that console.

15 CHIEF LYSTAD: Okay, thank you.

16 CHAIR: Commissioner Dodd.

17 MR. DODD: You made reference to an
18 investigation, or something with the Police
19 Foundation, and I'm not really sure what that
20 is. Can you explain that a little bit?

21 DEP. CHIEF BACKER: My understanding is
22 that Broward County has hired the Police
23 Foundation to conduct an after action into the
24 response for lessons learned and best practices
25 going forward. That would be an independent

1 investigation separate from what FDLE has been
2 doing, separate from what this commission has
3 been doing.

4 CHAIR: And you weren't here on Tuesday.
5 I represented in my opening remarks that they
6 have been, and I've been in communication with
7 them, and we're communicating with the, and
8 coordinating with them, so we're aware of what
9 they're doing.

10 MR. DODD: And that's including everything
11 with the incident, I mean --

12 CHAIR: No. It's a narrower review than
13 what we're doing. The FDLE executive
14 investigation is extremely narrow. I'd say the
15 Police Foundation is a little bit broader, but
16 nothing is as broad as what we're doing.

17 MR. DODD: Okay.

18 DEP. CHIEF BACKER: And they've already
19 been on site with us, and we've already met
20 with them, and spoken with them several times.

21 MR. DODD: And then my second question
22 deals with, it was kind of mentioned just now
23 about the regional meetings, but the input that
24 Coral Springs has had into the radio system
25 upgrade that Broward County is looking into.

1 Obviously, there's been some more information
2 here this morning to look at, you know,
3 cooperating together, so are those meetings,
4 those regional meetings, a lot of information
5 sharing between agencies, and not just Coral
6 Springs but, but I was just curious about your
7 input into those meetings.

8 DEP. CHIEF BACKER: I'm going to turn that
9 over to Kathy to answer because she attends the
10 meetings. I do not.

11 MS. LIRIANO: So, with the regional
12 meetings, they are actually very informative,
13 and it's good because we get to learn a little
14 bit of their processes, and they get to learn
15 about our processes, and at the end of the day
16 we can just kind of bounce ideas off each
17 other. At the end of the day we're all in the
18 same industry, public safety, and providing the
19 best service in the communications field. So,
20 there's a lot of lessons learned with actually,
21 because a lot of these meetings include
22 operations, a lot of chiefs, sergeants,
23 lieutenants from different agencies that are
24 part of the regional system.

25 So, we have, are involved from CAD

1 portions to, to the radio, so we go in there
2 and be, we're being informed. Last month I
3 attended a meeting at Motorola where they went
4 more in depth about their radio system, what
5 they procured, and explained different
6 processes, you know, had presenters just go
7 into more detail so we were just as informed as
8 the rest of the county, you know, users that'll
9 be, you know, procuring that radio system.

10 MR. DODD: So, I think that's a great
11 thing for this commission. If we're going to
12 recommend more consolidated regional
13 communications systems, that we, part of that
14 would be the groups coming together, the task
15 force, whatever that would be entitled of that
16 communication sharing. So, thank you.

17 CHAIR: Secretary Carroll.

18 SEC. CARROLL: Just a point of
19 clarification, not so much a question, because
20 based on what Sheriff Judd was asking I do
21 agree that both parties had a responsibility to
22 make sure what was on the console, but I
23 thought yesterday based on testimony from
24 Broward that they had the information and made
25 a conscious decision because of the hundred

1 channel limit of what they could put on the
2 console that they elected to do with one set of
3 data and not the other set of data.

4 So, I'm not sure who or how that decision
5 was made, but I still agree with Sheriff Judd
6 that at some point both parties should have
7 understood what the decision was, and what the
8 ramifications of that decision were. So, I'd
9 just like some clarification around that, in
10 terms of -- and I don't need it today, but
11 we'll get it later on, because I, it was just
12 my impression that the information was given,
13 and there was a decision that was based on
14 capacity and that hundred channels.

15 But there was no discussion after that
16 decision was made I take it, because your
17 testimony today is you had no idea that it
18 wasn't on there. So, the breakdown was after
19 that decision was made there was no
20 communication during that process or after that
21 process that it was not going to be included on
22 the console, correct?

23 DEP. CHIEF BACKER: Correct. And I
24 believe, you know, we're all in agreement that
25 that would be a process improvement going

1 forward to make sure that something like that
2 doesn't happen again.

3 SEC. CARROLL: And just -- and this is my
4 ignorance to radios, but when you said you only
5 reached forty eight percent capacity, if in
6 fact they had done a patch onto the main
7 channel does, does your capacity, would that
8 increase the capacity the folks in the Broward
9 radio system to communicate, or would it simply
10 add to your capacity? Does it add to the
11 capacity of both sides equally?

12 DEP. CHIEF BACKER: So, I understand there
13 might be some ambivalent information about
14 that. My understanding in lay terms is that
15 when we patch we absorb that load. I
16 understand there might have been some testimony
17 here yesterday indicating that that's not the
18 case. I think that's a better question for
19 Motorola and their engineers.

20 CHAIR: Well, and Cindy will be back here
21 when we get finished, from yesterday, and that
22 might be a good question for Cindy, see if she
23 knows. And there is somebody here from
24 Motorola still, and we can bring them back up.

25 DEP. CHIEF BACKER: Yeah, I think that's a

1 great question. I'd love to know the answer,
2 you know, to that as well. My understanding is
3 that's the way it is, but that may not be the
4 case, so I think that's a great point to
5 clarify.

6 CHAIR: Mr. Schachter, you're next.

7 MR. SCHACTHER: I want to -- Chairman Dodd
8 brought up a good point, is that, you know, by
9 having each of these agencies come up here it's
10 helpful, but to actually effect solutions you
11 need to have everybody working together in the
12 same room. And the Broward League of Cities,
13 School, and Community Public Safety Task Force
14 is the task force that I am on, and also the
15 newly formed School and Safety Director April
16 Schentrup is on that, and the gentleman that
17 heads that is the Mayor of Sunrise Mike Ryan,
18 who has the support of, of every public safety
19 person that I know, and is doing a tremendous
20 job.

21 That's the ones that actually already
22 issued their first report, and Mayor Ryan has,
23 has a breadth of knowledge, and because it
24 takes coordination between all of these
25 different entities everybody needs to be in the

1 same rook working together at the same time,
2 and so I think that that is a great idea.

3 Because just to have each one of these
4 entities coming up here, it's wonderful, it
5 gives us information, but everybody needs to be
6 in the room working together, because obviously
7 it's what, what they're saying, you know, has
8 an effect on someone else, and it needs to be
9 obviously back and forth. So, if we could
10 effect that and, and, you know, have them
11 working together to, to fix all this, I think
12 that would be extremely helpful.

13 Go ahead, I'm sorry, were you going to say
14 something?

15 CHAIR: No. Were you finished, or no?

16 MR. SCHACHTER: I just wanted to ask,
17 Commissioner Lystad, or Chief Lystad brought up
18 some questions, and I was just a little
19 confused. So, do you think that this is going
20 to work, you know, like if they're able to get
21 on the new system? I was just a little
22 confused by, you know, the testimony. I'm not
23 as educated in that area as you.

24 CHIEF LYSTAD: So, in response, I think it
25 can. It can work. My concern is over system

1 integration. Any system can be integrated
2 together, and as long as Coral Springs is
3 talking to Broward Sheriff's, and Broward
4 Government about how the systems integrate, and
5 how we'll talk to each other, that's my
6 concern, is to make sure that they're, they're
7 both going to be able to integrate and work
8 together seamlessly.

9 And the other concern I have is, is that,
10 you know, cities are formed, and cities have
11 police departments, and some cities have more
12 revenue, and money to add features and, and
13 benefits, and there's, there's always, there's
14 always that next gadget that everybody wants,
15 and I want to make sure that Coral Springs, you
16 know, they're, they're going to be looking out
17 for their residents as well, they don't want to
18 lose features. But as I understood the
19 testimony today the systems will work together,
20 the systems will be integrated together, and
21 the cities actually will have the option if
22 they want to pay the extra money to add the
23 features that Coral Springs has, such as GPS
24 for the officers, which I think it phenomenal.
25 It's very easy to lose track of where an

1 officer is at in the heat of the moment, in the
2 heat of foot chases, and the fact that they
3 have that I think is phenomenal.

4 MR. SCHACTHER: And then my last question
5 is, Chief, you've stated that you would like
6 out assistance to help push this issue and make
7 sure this gets done. In your opinion how can
8 we, because I understand there's been conflict
9 between the City and the County, how do you,
10 you know, and obviously this doesn't happen
11 unless everybody is transparent and honest
12 here, how, in your view how can we help make
13 sure that happens, and do you think that, you
14 know, having the League of Cities Task Force
15 that I'm talking about coordinate, and Mayor
16 Ryan, is a good suggestion?

17 DEP. CHIEF BACKER: I'll answer the second
18 part first. Any influence and help that we can
19 get, I know Mike Ryan is, like you said, a
20 wealth of knowledge when it comes to radios
21 and, and all these things, and I think
22 certainly having support from multiple entities
23 would be, would be helpful. I'll speak from
24 the fifty-thousand-foot overview, and at the
25 end of the day what we need is, and what we're

1 telling you we're willing to do, is be flexible
2 to a certain extent as it relates to the
3 governance and the programming, and
4 accessibility to CAD.

5 Right now, I don't feel that there's -- I
6 don't think either party is being flexible
7 enough to really be committed to making that
8 work, and --

9 MR. SCHACTHER: What party are you talking
10 about?

11 DEP. CHIEF BACKER: The County and us. We
12 have a way of doing business that we feel best
13 serves our community, and the inability to have
14 a modicum of program and control over that CAD
15 impacts that. I understand from a technology
16 standpoint why you want less hands meddling to
17 insure system continuity, I get that, but we'd
18 be talking about one administrator, not all
19 thirty- eight people in our system, you know,
20 having that level of access.

21 So, again, but those discussions are
22 ongoing. We have met. I do believe in a
23 perfect world if we can agree on how that works
24 best for everybody, with a little bit of give
25 and take, us going on the CAD and remaining

1 with our radio system would be the best
2 solution right now going forward.

3 MR. SCHACHTER: It's been five months
4 since this tragedy. I don't want to wait
5 another five months. What do we need to do to
6 fix this?

7 DEP. CHIEF BACKER: Everybody has got to
8 be a little bit more flexible. There has to be
9 a directive that what's best for maybe just the
10 County, if it's not best for the end users, and
11 you're not taking their feedback, it's not
12 incorporated quickly, or it's not considered,
13 or you don't give them the level of control
14 that they're looking for to program, that's not
15 necessarily the most efficient.

16 MR. SCHACTHER: I would, you know,
17 appreciate your insight.

18 CHAIR: Commissioner Swearingen, you're
19 next.

20 COMM. SWEARINGEN: Thank you, Mr. Chair.
21 Chief, first I want to say thank you to you and
22 Chief McKeone for your transparency today, as
23 well as your willingness to be open minded
24 about moving towards the regional system, which
25 I think we all agree is in the long term the

1 best interest of the citizens here in Broward
2 County. And I'm not a radio expert, so I
3 apologize. I just want to clarify.

4 Yesterday we heard testimony that one of
5 the concerns about Broward's system was that
6 there were other entities other than public
7 safety on their system, local government. And
8 we heard testimony, while we haven't heard any
9 definitive, the impact that had on the system,
10 we did hear testimony from Motorola that it's
11 logical to conclude that having those
12 additional entities on there in a time of
13 crisis could have led to the throttling issue
14 because you've got additional entities other
15 than a public safety entity turning on their
16 radio, or changing channels, or whatever.

17 In your testimony today I believe you
18 indicated on Page 4 that you have local
19 government entities on your system as well, so
20 my question is are you concerned that if the,
21 the incident was in Coral Springs, and you're
22 adding all of these public safety entities onto
23 your system, I realize that day you only hit
24 forty eight percent, but that's because I think
25 most of the traffic was being pushed to

1 Broward, or -- are you concerned that if the
2 incident were to happen in Coral Springs and
3 you're adding law enforcement, that these other
4 entities on your system, you'd be making
5 basically the same mistake that Broward made by
6 having entities other than public safety on
7 your system?

8 DEP. CHIEF BACKER: I am not. As I gave
9 you was the total number of uses, they're not
10 all working at the same time. I believe we
11 have more than enough capacity to handle any
12 event in Coral Springs.

13 COMM. SWEARINGEN: Thank you, Chief.

14 CHAIR: Senator Book, go ahead.

15 SEN. BOOK: Thank you, Mr. Chair. And
16 this is a question for, I guess for all of the
17 sheriffs in the room on the commission. I was
18 -- on Page 7 we're talking about Coral Springs
19 fire, and they had three patches that worked.
20 Perhaps I, I don't know enough about the
21 intricacies of fire versus law enforcement.
22 Why are we not talking about an issue that the
23 fire had? Did -- was there issues that we're
24 just not talking about? Why is that?

25 CHAIR: No, I think -- because Coral

1 Springs in their communication center
2 dispatches fire and police, 911 for all of it.
3 Coral Springs contracts with Parkland, so Coral
4 Springs fire was the host agency for fire, so
5 they were able to effect the patch with other
6 channels, and they had all of the other
7 channels in their console, they were able to
8 click the button, and they were able to effect
9 it without a problem, and it was their
10 responsibility.

11 As you heard under the protocol here in
12 Broward County is, is that the Broward County
13 Sheriff's Office was the host agency because
14 they are the police, excuse me, the police
15 provider in Parkland, but for whatever reason,
16 because of whatever reason they didn't have the
17 Coral Springs primary police channel to click
18 the button on to patch with 8A. They didn't
19 have it, so when they didn't have it, and they
20 couldn't effect it, somebody from, a duty
21 officer according to the testimony from the
22 Broward Sheriff's Office, picks up the phone
23 and calls Coral Springs and says patch
24 14JOINTOPS2, which is a mutual aid channel, but
25 nobody was on that channel.

1 And that would -- that gets back to some
2 of the questions I had earlier, is, is that
3 again in the perfect world that doesn't exist
4 is, is that could Coral Springs have said, hey,
5 guys, wait a minute, we understand that you
6 don't have it, and you can't effect the patch,
7 and the patch won't work, but why don't we
8 patch 8A onto our system. But then the problem
9 you would have had was, is that if they had
10 taken it then, all of the deputies on the
11 street wouldn't have been able to necessarily
12 communicate with their dispatch.

13 So, there's -- there's all kinds of --
14 does that answer your question?

15 SEN. BOOK: I guess part of where I'm
16 trying to, to tie up, is the seamlessness, the
17 continuity, that it seems to perhaps exist for
18 whatever, I mean --

19 CHAIR: I don't think it's a fire issue.
20 I think that the fire, the fire patch, and you
21 can speak to this, the fire patch worked
22 because everybody had what they needed to have,
23 and they were able to effect it. It's not a --
24 the patching system works.

25 SEN. BOOK: I think it's the procedures

1 perhaps.

2 CHAIR: It's the procedures, yeah, go
3 ahead if you want to speak to --

4 DEP. CHIEF BACKER: Well, I have Assistant
5 Chief Mike Moser from the Coral
6 Springs/Parkland Fire. He can speak to any
7 fire related issues.

8 CHAIR: And it's the patch that's in
9 question, the patch --

10 ASST. CHIEF MOSER: Right. The only thing
11 I wanted to elaborate on, and you had brought
12 up a good point. The patch that occurred
13 between the Coral Springs Fire talk groups and
14 the County mutual aid talk groups that the fire
15 department used is the same exact patch that
16 would have been attempted between Coral Springs
17 main and the 140PS channel. It's exactly the
18 same. They were successful when our fire
19 dispatchers did them from our console, so I
20 just want to make sure that you understand it's
21 the same thing.

22 It's not that we were trying to patch
23 channels, and then another agency was trying to
24 patch different systems together. They're --
25 they're two systems that were done on the fire

1 side correctly and, and I don't want to say
2 correctly, they were successfully done, and
3 they worked, and the other patch, we're unaware
4 of what the issue was.

5 CHAIR: Sheriff Judd.

6 SHER. JUDD: Yes. Chief, my closing word
7 on this is that you have to look out for the
8 best interests of your community, and we
9 understand that. And we talked about the
10 regionalization, and you don't want to lose
11 anything, but I strongly encourage regional BSO
12 and you to sit down and work out these issues,
13 so you get to a win/win, because the last thing
14 you want is something forced on both of you
15 that neither of you like or is in your best
16 interest. And this train is up on the track,
17 and it's rolling, and if you don't see it, or
18 hear it, or feel it, it's going to run over
19 you, and then you're going to be stuck with the
20 results.

21 So, at the end of the day I hear the ideal
22 world, but in the real world, the real world is
23 BSO has got to understand they've got to be as
24 sensitive to your needs as, as they possibly
25 can be, because, yes, they're regional, but all

1 service is local, and it's individualized to
2 the people that need help, and everybody is
3 entitled to the absolute best service. So,
4 what I suggest, I would operate with a sense of
5 urgency. I'd get everybody in a room and start
6 huddling and say let's fix this thing before
7 they give us a fix that we may not like.

8 DEP. CHIEF BACKER: Yes, sir, I think
9 we're committed to doing that. We will make
10 sure that those meetings, you know, we
11 re-engage in those meetings. We've already had
12 some. I do want to clarify. It's not BSO,
13 it's the County where we've got to really get
14 together. I don't think there's been an issue
15 between us and BSO as it relates to
16 communications.

17 SHER. JUDD: Okay, I understand. But
18 whoever, whoever the players are in this thing.

19 DEP. CHIEF BACKER: Understood.

20 SHER. JUDD: And -- and at the end of the
21 day it needs -- it has to be, and it can be a
22 win for everyone. But the last thing you want
23 -- because we all grew up in local government,
24 the last thing we want is somebody from the
25 outside coming in and saying, well, since you

1 all can't fix it we're going to fix it for you,
2 and then you're going to have to get used to
3 it. That's not ideal.

4 DEP. CHIEF BACKER: Agreed, sir.

5 CHAIR: Thank you, Chief, we appreciate
6 your testimony. So, we're going to have to do
7 some --

8 DEP. CHIEF BACKER: Thank you all.

9 CHAIR: Thank you very much. We're going
10 to have to do some schedule adjustments, which
11 we'll do, but for right now we've been at it
12 for two hours. We still have Cindy Cast to
13 come back up and answer any questions you have.
14 Then I know at least one commission member has
15 asked for Ms. Henry to come back up and respond
16 to a question, so let's go ahead and take a
17 fifteen-minute break. Well come back and then
18 we'll wrap up with communications, and then
19 move on to the next topic.

20 (Thereupon, a recess was had and the meeting
21 continued as follows:)

22 CHAIR: We're going to resume here. Cindy,
23 if you would come back up please. So, Cindy
24 Cast from Miami-Dade Communications is back to
25 answer any questions you have. Perhaps, you

1 know Secretary Carroll, if you want to I think
2 there was that one question that you had. It
3 was a technical question, if you want to ask
4 that of Cindy maybe -- did you hear the
5 question before?

6 MS. CAST: Yes, I did.

7 CHAIR: Can you -- can you respond to
8 that?

9 MS. CAST: Yes, I can.

10 CHAIR: Okay, go ahead.

11 MS. CAST: Okay, so technically the
12 question was asked how does patching work
13 between two separate systems, does the
14 capacity, or the loading of the patch carry it
15 on from one system to the next. So, in a
16 scenario, and I'm not talking specifically
17 about their systems but just in general,
18 technical radio systems, two separate ones,
19 when you patch a talk group you're using a
20 resource, and I'll go back to the example I
21 used yesterday, a five-channel truck system.
22 One channel is a working, I mean a control
23 channel, four channels are working channels.

24 With another system, we'll say this one
25 just cause of my fingers, is a four-channel

1 system, one channel is a control channel, so it
2 has three channels that are working channels.
3 If one talk group gets patched between then any
4 time anybody talks on either one of the systems
5 on that talk group it uses one channel, which
6 is the transmit and frequency pair, on each
7 system at the same time.

8 So, that means for the five-channel system
9 over here, one control channel, four working
10 channels, every time someone talks on that talk
11 group that is patched one channel gets used,
12 only three left available frequency pairs to be
13 utilized. On this channel there were three
14 working channels, every time it gets used only
15 two channels are left. So, it doesn't share
16 the capacity of the frequencies to the other
17 system, they both tie up a frequency pair on
18 each of the individual infrastructures. And
19 that's the way it works across the board unless
20 the control channels have some kind of shared
21 control channel between both systems, which is
22 not the case here.

23 So, that means that, for your question,
24 the capacity cannot carry over from Coral
25 Springs to help BSO, and BSO's capacity cannot

1 carry over from BSO's system to help Coral
2 Springs infrastructure wise.

3 CHAIR: Actually, it doesn't help
4 anything.

5 MS. CAST: Not the infrastructure to help
6 capacity. Each system independent has to
7 support the capacity.

8 CHAIR: Right. You would -- you would
9 still have -- if you had throttling on one the
10 patch isn't going to fix the throttling issue.

11 MS. CAST: If you have throttling on one
12 system, and the system is working without
13 throttling on their own independent talk
14 groups, on the patched group it will have
15 experienced the throttling, because they won't
16 be able to converse and access the channel of
17 the other system, because it doesn't have any
18 working channels to give it access to.

19 CHAIR: Secretary Carroll, does that --

20 SEC. CARROLL: Yes, thank you.

21 CHAIR: Okay. Go ahead, Commissioner.

22 MS. LARKIN SKINNER: Yesterday we learned
23 a little bit about queuing, which then might
24 lead to throttling later, or whatever happens.
25 But what I'm interested in is what is the

1 experience like for officers and deputies in
2 the field, and, and the experience like for
3 dispatch, let's say, when queuing happens?

4 MS. CAST: So, every radio is very
5 complex, and it could be programmed
6 differently, so it could be programmed, the
7 radio itself, so when a queue takes place that
8 means you have four working channels, all four
9 working channels are being talked on on
10 different talk groups. Someone goes to key up
11 their radio, but these are already currently
12 being utilized so there is no available working
13 channel for the talk group to talk on.

14 The radio, one way of programming it, it
15 gives a high-pitched squelch tone, so that high
16 pitched squelch tone is different than any
17 other tone the radio normally hears, so the
18 radio user knows I'm on queue. Now if they
19 have training they know in some configurations
20 the way it could be programmed is they continue
21 to press to the push to talk button on the
22 radio, the radio will eventually give it the
23 regular access tone saying, okay, now you have
24 a free working channel, you are now open
25 microphone for you to communicate. And that's

1 from a user side.

2 Sometimes, depending on the way the radio
3 is programmed it might not have a high-pitched
4 tone. It could have a long deep tone. Again,
5 there's different tones that could be utilized
6 depending on the programming. And sometimes if
7 you hold the PTT it will not automatically give
8 you the next working channel, you might have to
9 let go and hold it again.

10 The problem is when you let go and hold it
11 again, if you don't utilize the feature of
12 continuing to hold it you lose your line. It's
13 sort of like you're back in the bank, you got
14 out of line, and you went all the way to the
15 back of the line if you let go, whereas if you
16 continue to hold you are the next person,
17 because the system sees you, you got logged in
18 that your unique radio wanted to actually
19 communicate, so you're the next in line, and
20 that's when you get the next available working
21 channel.

22 MS. LARKIN SKINNER: So, in theory if
23 queuing happens someone may be waiting, their
24 turn comes up, they transmit their message, but
25 whoever needs to answer them then is also going

1 to be queuing, so there will be a delay --

2 MS. CAST: So, the infrastructure could be
3 set up so that there is different priority
4 levels. Every radio has a unique
5 identification number. That unique
6 identification number could have a different
7 priority level, so if you queue, if you press
8 your push to talk and you're a higher priority
9 than someone else that's pushed it, you still
10 go ahead of them.

11 The console usually, not always, but
12 generally the console has the highest level of
13 priority, so a console could always, if it is
14 configured in this manner, be able to
15 communicate and go over any other radio in the
16 field that's talking. That's a general best
17 practices, but sometimes the consoles might not
18 be set in this priority level, it depends on
19 the configuration. Which is one of the things
20 I started yesterday, is radios are very
21 complex, there is a lot of different features,
22 so you have to really see the details of how
23 it's programmed and the configuration of the
24 infrastructure to know.

25 MS. LARKIN SKINNER: So, do you know is

1 that best practice in the public safety
2 industry, that the console would have the
3 priority?

4 MS. CAST: Yes.

5 MS. LARKIN SKINNER: Okay, thank you.

6 CHAIR: Commissioner Dodd.

7 MR. DODD: Does the GPS mapping feature
8 that a lot of these new systems utilize, does
9 it require additional capacity, or is that like
10 data, metadata or whatever, that doesn't use
11 the frequency? How does that work?

12 MS. CAST: So, it depends. It's a very, a
13 complex answer. So, you could have an
14 infrastructure that utilize the capacity of the
15 radio frequencies to do GPS tracking, and
16 that's a data message that goes back and forth
17 to the infrastructure. Some systems are set up
18 that they have a separate core of frequencies
19 utilized for those data messages that go back
20 and forth, so it depends on where they're using
21 it, how they're sending the data packets, and
22 what's the back-end infrastructure to support
23 the mapping. So, there's -- both mechanisms
24 are available out there from vendors.

25 CHAIR: Anyone else? Chief Lystad.

1 CHIEF LYSTAD: I just want to have, if you
2 could, just explain a little bit about what
3 they call route fleet mapping, we call
4 profiles, and so there's always a different
5 perspective on that. As I understand Broward
6 profiles each individual agency controls that.
7 Can you either talk about profiles, and how
8 they should be created, or how they are, their
9 best practices so that they become more
10 effective for users?

11 MS. CAST: So, there's many different
12 forms of creating templates, fleet maps,
13 profiles, and that is basically the programming
14 that goes behind the scenes into the radio
15 itself. Some counties, some cities, choose to
16 take on the responsibility, so every user on
17 that radio system has to come to one specific
18 place, and they have to get it authorized by
19 that system administrator, and they can only
20 have the configuration that that system
21 administrator approves. So, across the board
22 any user, any discipline, they know exactly
23 what is the protocol of which talk group, which
24 zone, which system they have to move to,
25 because the system administrator which manages

1 the infrastructure has all of the data.

2 However, that could become very costly
3 because you have to have the staff to be able
4 to support all the different agencies that
5 might write off of your infrastructure, so
6 other agencies, what they do if they don't have
7 that level of staffing, is they might take on
8 the responsibility, is all of the internal
9 departments for that county or city come to the
10 system administrator for their county or city,
11 and any outside agencies that have a different
12 hierarchy go to an outside vendor, contractor,
13 that work for the same infrastructure, or
14 manufacturer, that does the work for them.

15 But again, in that case there is some
16 difficulty from a system manager perspective
17 because they don't know how does that radio
18 program, they don't know does that agency have
19 that talk group or not. And having too many
20 talk groups on a radio doesn't become helpful
21 because the officer or deputy will never be
22 able to find it on his radio. So, it's not
23 just the radio programming itself, but having
24 the training, or the knowledge by the different
25 officers or deputies on how to move around in

1 their radio, and how to access the different
2 talk groups.

3 So, best practice would be making sure
4 that the system administrator knows the
5 information, whether they do it or a vendor
6 does it outside, and also having training put
7 in place so that the people who actually have
8 the device are able to utilize all the
9 functionality and features.

10 CHAIR: Anybody else? So, is there -- as
11 you sat here listening to the presentations
12 after your presentation yesterday is there
13 anything that you feel that you need to share
14 with us to provide clarification from what
15 we've heard that in your expertise is something
16 that we need to know about, that needs
17 clarification?

18 MS. CAST: I think each of the individuals
19 that spoke on the separate infrastructure
20 systems, and they answered the questions
21 provided, all of the information that was being
22 requested by this commission, if there is
23 something that someone did not understand I'm
24 here to clarify it, but I think each individual
25 agency provided details.

1 CHAIR: And everything in your
2 understanding, I just want to make sure that
3 there's nothing that from your perspective, and
4 hearing it, it's kind of, you know, that catch
5 all, is there anything that you saw, heard,
6 that needs clarification, so we have an
7 accurate understanding. Is there anything
8 that, that sticks out in your mind, or do you
9 feel that from what you've heard is, is that
10 everything was accurately conveyed?

11 And I'm not saying that anybody
12 intentionally provided any inaccurate
13 information, I'm not saying that, but there was
14 a lot talked about, and you are here as our
15 subject matter expert, so that's why I'm asking
16 you, and the question is, is there anything
17 that sticks out in your mind that you've heard
18 in the last day and a half that this commission
19 would benefit from your knowledge and expertise
20 to clarify?

21 MS. CAST: So, each of the different
22 system presentations provided detail on the way
23 the systems work. They talked about the key
24 components, such as fleet mapping, the type of
25 talk groups that might be on the radio, which

1 ones might not have been on the radio. They
2 talked about the console having the capability,
3 or not having the capability because they had
4 the limitations of the talk groups that the
5 console was able to utilize.

6 They talked about the new system, and the
7 capacity of the new system. So, they shared
8 all of the key components on talk groups,
9 consoles, the agencies and users that were
10 using it, and the amount of utilization that
11 each system had, and what was available and
12 what was not available, so I believe that they
13 covered all of the basis. There weren't any
14 catch you's, or things that, that might not
15 have been relevant based on what they said.

16 CHAIR: Great. Senator Book, go ahead,
17 then Mr. Schachter.

18 SEN. BOOK: Thank you, Mr. Chair. And
19 thank you so much for providing us with a lot
20 of information. But in, for example, in
21 Miami-Dade are you doing something different
22 than what we're doing in Broward, something
23 better, something that could be improved that
24 we could glean that could enhance what we're
25 doing, looking at and hearing what you've

1 heard, that maybe if that were in Miami you
2 would change?

3 MS. CAST: So, the infrastructure in
4 Miami-Dade is very different than the
5 infrastructure utilized here. Our system was
6 twenty years old, and we did replace it, which
7 is a really long process. It took years to
8 replace and move everybody over. So, I guess
9 to give you a background of the Miami-Dade
10 system, we have countywide simulcast trunk
11 systems. There are a little over thirty
12 thousand radios on the system, between mobiles,
13 portables, and desktops and consoles, but we
14 have two separate systems that are countywide
15 simulcast.

16 One system has only law enforcement, which
17 is police, state, federal, local, cities,
18 tribal, and corrections. That's one system. A
19 separate system has everybody else, which would
20 be fire, EM, local government, any of the
21 departments, our seaport, our airport, they all
22 utilize the same system. So, out of the thirty
23 thousand, again two separate systems, they sort
24 of have the same coverage to some extent, the
25 majority of them have the same exact coverage,

1 so if one system has a failure the protocol is
2 to move to the other system as their backup.

3 So, it's a completely different
4 configuration, it's been in place for a long
5 time. We also are self-maintained. We have a
6 little over fifty individuals who run and
7 operate the radio system full time,
8 twenty-four/seven every day of the year. We
9 have people on call. We support over
10 thirty-four city police departments that work
11 on the system. They don't have separate
12 individual systems from those thirty-four.

13 There are in the county six different
14 separate systems that are outside of the
15 counties, and we do exactly what they do in the
16 example that they gave. We have on our
17 consoles a talk group for that city that has a
18 separate system, and we patch to it. And
19 that's what we do every day for any quick
20 incident that takes place, so it's the same
21 protocol, or procedures that they do. Our
22 configuration, or the way we're designed, is
23 different, but it might just be different
24 because, again, we're self- maintained. The
25 agencies, we have over a hundred twenty-five

1 agencies on our system. So, it might be
2 different just because of that.

3 When I explained radio infrastructure
4 systems, each one is very unique, and those key
5 questions sort of are fundamental on how
6 they're designed.

7 SEN. BOOK: Thank you. Mr. Chair, can I
8 -- thank you. The other question that I have
9 is have you experienced, I mean I know that in
10 Miami-Dade there have been catastrophic events
11 throughout the history, have you experienced
12 some of the challenges that, that presented
13 itself here on February 14th, the throttling,
14 the queuing, whatever?

15 MS. CAST: Okay, so our infrastructure,
16 because they're two separate ones they have two
17 separate groups of everything, so it's twenty
18 channels on one, so I don't have enough hands
19 for that, there's twenty channels, one control
20 channel, so you have nineteen working channels
21 on one, twenty channels, one control channel,
22 nineteen working channels. Two separate
23 control channels, two separate infrastructures,
24 so throttling, or the control channel being
25 inundated with data, has not taken place in the

1 eighteen years I've been there.

2 Could it, I don't know; I've never seen it
3 there because of the way that we handle and
4 manage the, or the protocols, the procedures we
5 have in place, the training that's done to the
6 individuals that use the system; so, so far,
7 I've never seen it.

8 Queuing, which is in our case nineteen
9 working channels get utilized, and the
10 twentieth person comes up, they get the high
11 pitch beep, yes, we've had queuing, and they
12 hold the button and they get in line, they go
13 out. So, it's hundredths of a second that they
14 might experience, it doesn't happen often, but
15 in big storms, or big incidences, queuing could
16 happen, but it doesn't impact the operation, or
17 the response to the operation. It has never
18 gotten to that level.

19 CHAIR: Okay, the last question, Mr.
20 Schachter.

21 MR. SCHACHTER: I mean obviously this is
22 something that I'm very curious about, and that
23 is why did we not do two separate systems like
24 Miami did, and if we would have had that would
25 that have, would we, that have fixed all of our

1 problems, and Jan Jordan would have been able
2 to command the BSO on, on campus? That's
3 something that, you know, I don't know if you
4 can answer, or somebody can answer. I'm
5 curious about that.

6 And also, should we be switching to two
7 separate systems? It sounds like it makes more
8 sense to me, but, you know, I'm not an expert.

9 CHAIR: Okay, so first they already said
10 they are switching to two separate systems.
11 The new system will be a law enforcement only
12 system, a public safety system, and then
13 everybody else will be on something else. So,
14 they already said that. And you can answer if
15 you want, but I don't think that you can answer
16 as to why Broward County made decisions about
17 one or two systems --

18 MS. CAST: Right. So, every city, or
19 county, or state, when they go into developing
20 a radio system they go through a huge process
21 of answering questions about how best to
22 deliver the services, and what is the, the
23 funding that they have available to do that.
24 And I'm sure those decisions, or discussions,
25 took place, and I'll let someone from Broward

1 come up and, and answer more specifically.

2 CHAIR: Okay, Cindy, we very much
3 appreciate -- yeah, go ahead.

4 MR. SCHACHTER: I'm not -- I'm not sure,
5 you know, of that. It was my understanding
6 that it was just the buses that are going to be
7 offloaded, and --

8 CHAIR: Okay, we're going to bring
9 somebody. You asked for the County
10 Administrator to come back up. She's going to
11 come back up in a second, you can ask that
12 question. Cindy, we very much appreciate you
13 being here. Thank you. You are a wealth of
14 knowledge, you did a great job, and we
15 appreciate it. Thank you very much.

16 MS. CAST: Thank you, sir. Thank you.

17 CHAIR: One question, Chief Backer, would
18 you come up for a second? And I tried to find
19 you at the break, I couldn't, so I'm going to
20 put you on the spot and ask this question now
21 that I'm competent of what your answer will be.
22 Will you please by next Friday, a week from
23 tomorrow, provide me and the commission, I'll
24 share it with everybody, a list of what Coral
25 Springs concerns are, and what you find to be

1 impediments to joining the County CAD system?

2 You have a list of the things, and we
3 didn't get into that, but you alluded to that
4 there are issues, and there are things that you
5 feel like that Coral Springs has probably dug
6 in on, there's things that the County has dug
7 in on. The County Administrator is going to
8 come up in a second and I'm going to ask her
9 for the same thing. So, will you by a week
10 from tomorrow provide us with a list of what
11 Coral Springs feels needs resolution before you
12 would be willing to migrate over to the
13 County's CAD system?

14 DEP. CHIEF BACKER: Two things. One,
15 absolutely we will hundred percent provide
16 that. I can't see Kathy behind me but I'm sure
17 she's writing it down, and she will have a
18 comprehensive document probably before the
19 timeline that you're asking. Secondly, I would
20 like to note that after we concluded we did
21 have a side meeting with Bertha Henry and a lot
22 of her staff, and we've all exchanged
23 information again, and we're talking about
24 getting together sooner than later to work on
25 this issue.

1 I think we have a commitment from Ms.
2 Henry to collaborate and work towards resolving
3 this. I'm confident that if each entity is
4 reasonable and practical that we'll get that
5 done.

6 CHAIR: And anything we can do to
7 facilitate it, so I appreciate your willingness
8 to provide that list by a week from tomorrow.
9 Thank you. Appreciate it. Thank you.

10 DEP. CHIEF BACKER: Yes, sir, you will
11 have it.

12 CHAIR: Thank you. Ms. Henry, would you
13 come back up? I'm sorry, Senator, I'm sorry,
14 go ahead.

15 SEN. BOOK: Thank you. And as the County
16 Administrator comes up I just would ask the
17 Chair if, because plantation is also one of
18 those that is not part of the regional system
19 could we ask of them, I know they are not here,
20 but send them something, because I think what
21 we're trying to do is get everybody on the same
22 page, and have them a part of those discussions
23 so that we can work for that unified?

24 CHAIR: I'll send a letter to them, and
25 reach them, and ask them, yes, to do that. So,

1 I'll just ask you a couple of questions, and
2 then open it up to questions from everybody
3 else.

4 MS. HENRY: Yes, sir.

5 CHAIR: Is, is that do we have your
6 commitment to work collaboratively, and to seek
7 a compromise with Coral Springs, and
8 potentially, we don't know the issue with
9 Planation, but to work collaboratively and
10 compromise where you can to get to a place
11 where Coral Springs feels comfortable, and the
12 County feels comfortable in getting at least
13 Coral Springs and the County on the same CAD
14 system?

15 MS. HENRY: Absolutely.

16 CHAIR: Okay. And will you -- the same
17 question, will you by a week from a tomorrow
18 provide me with a list of what the County sees
19 as issues that need resolution, that require
20 compromise between the County and Coral
21 Springs?

22 MS. HENRY: The answer is yes. And as
23 you've indicated we had a short session a few
24 minutes ago, and admittedly I was not aware
25 that, and I guess the term was used, there was

1 a conflict. I -- I -- at my level I'm
2 interacting with the, with the City Manager,
3 and City Manager Goodrum and I don't have any
4 communication challenges, so if there's some
5 issues at the staff level they will certainly
6 get those ironed out so that we can identify
7 where there are some, some differences, and
8 we'll work them out.

9 We have -- we have a community that
10 reached out to us and said, hey, look, we'd
11 like to be able to dispatch for ourselves, do
12 our own call taking and dispatch, and we said
13 as long as you're on, you're willing to stay on
14 the County's CAD, because we certainly want to
15 not go backwards in terms of having call
16 transfers, we're happy to accommodate that, and
17 they were working towards that aim.

18 So, we are open to whatever works best for
19 the system in its totality, so you have my
20 commitment that we'll do that, and we'll get
21 you that list.

22 CHAIR: Great. Thank you, I look forward
23 to receiving that by next week. Mr. Schachter,
24 you had a question for the County
25 Administrator.

1 MR. SCHACHTER: I just wanted to clarify.
2 On March, you said the first quarter of 2019
3 you'll have a new system for, for the buses, is
4 that correct? And then with the new, and then
5 what about fire and EMS, and -- I'm just trying
6 to see if Miami's system and how they have
7 everything separated, will that, is that the
8 way we're going to have it, or not?

9 MS. HENRY: So, let me start with their --
10 we will have two systems, a local government
11 radio channels, I mean for non-public safety.
12 What will be up and running 2019 would be all
13 of the County agencies that are currently on
14 the system that are not law enforcement, so
15 they will be on the local government radio
16 system. The City of Fort Lauderdale, the City
17 of West Park, there are a couple of cities that
18 have reached out to us and asked if they could
19 come on our local government radio system, and
20 we said yes, and we would work with you to
21 program you in. Now, whether they will be on
22 at 2019, at when we're up, I can't say that at
23 this point because I don't know what their
24 requirements are, other than maybe the smaller
25 city West Park.

1 As the school board is also working with
2 us to come off, their, the buses if you will,
3 to come off of the radio system. I cannot
4 today tell you what their, what that timeline
5 is cause we're going through the requirements
6 with them as well.

7 But the remaining system that we're
8 looking to have available last quarter of 2019
9 will be just that one system, but it has been
10 configured with quite a bit of redundancy, so
11 we're a little different than Miami-Dade, and
12 what we were able to accomplish is, is based on
13 what is available to us today. A lot of, and
14 maybe she can speak to that, a lot of this is
15 about frequency availability by the FCC, and as
16 some of you may have heard they're trying to
17 move away from certain systems, and so with
18 the, with the frequencies that we are allowed
19 to have we believe we have the best system, we
20 have the redundancy that we need, and if we
21 find out that that's not the case we'll keep
22 pursuing it until we do.

23 MR. SCHACHTER: Are you saying that you
24 went to the FCC and they would not give you
25 more frequencies --

1 MS. HENRY: They were not available. They
2 were not available.

3 MR. SCHACTHER: And is -- is that a
4 problem, is that something that we should be
5 addressing, or --

6 MS. HENRY: I'd -- it's -- I don't know --
7 I don't believe that you as this committee
8 would have the ability to do that, because if
9 they're not available that means other entities
10 have them, and unless we're going to take them
11 from them, we wouldn't do that. And we didn't
12 believe that that was a big problem for us
13 because of the way the new system for us is
14 being reconfigured with the redundancy.

15 MR. SCHACTER: Are there any delays, or
16 any other impediments like what we're having
17 with Tamarac on the, you know, the other
18 system, the separate system that's supposed to
19 be up and running March '19, any impediments,
20 anything we should be aware of?

21 MS. HENRY: No, not at this time.

22 CHAIR: All right, well, thank you Ms.
23 Henry, we appreciate you being here. Yes,
24 Sheriff Ashley, go ahead.

25 SHER. ASHLEY: I'll just ask one question.

1 Her previous testimony that there may be some
2 cities that are looking to go away from the
3 regional communications, have you heard
4 anything of that from any of those cities?

5 MS. HENRY: Well, what -- what has come to
6 my attention, the City of Coconut Creek had
7 asked if they could have the ability to have
8 their own call taking and dispatch, but they
9 would stay on the regional system, and wanted
10 to make sure that they could use those assets
11 if they had their own dispatchers and call
12 takers, and the answer was yes.

13 If there are other communities that are
14 looking to leave they've not brought that to my
15 attention. I've -- but I can't say that that's
16 true or not, they've just not brought it to my,
17 to my attention.

18 CHAIR: So -- so does Coconut Creek
19 understand that if they were to do that, and a
20 911 call comes in, that they are creating a
21 situation where their citizens who are calling
22 in are not talking to the person that can get a
23 cop to them?

24 MS. HENRY: Well, for that city they've
25 indicated that they will stay on the CAD and

1 use the same protocols.

2 CHAIR: But the -- the 911 call would go
3 into the regional center.

4 MS. HENRY: It would go into the common
5 CAD, and yes, and they can, they can send the
6 call to wherever it needs to go, so they --
7 that was a commitment that they made in order
8 to continue to use the infrastructure.

9 CHAIR: Any other questions, last --

10 MR. SCHACHTER: Yes, Chairman, how can the
11 commission, because, because of the failures I
12 think there's -- maybe she's not aware of them,
13 but there are other cities that don't trust the
14 County system. How can we, you know, encourage
15 other cities, and, you know, make sure that we
16 don't have --

17 CHAIR: We can make recommendations, and
18 then we can put it in the report that we submit
19 on January 1st.

20 MS. HENRY: So, what I will do is reach
21 out to see if there are such cities, because
22 I'm not aware of them. So, I'll find out if
23 there, if there are, and I'll report back.

24 CHAIR: Okay, thank you, Ms. Henry, we
25 appreciate you being here. Thank you for your

1 staff, their cooperation and participation. We
2 appreciate it. Thank you very much.

3 MS. HENRY: Thank you.

4 CHAIR: All right, so we're going to move
5 on now, so just for housekeeping we've got --
6 it's about 11:30. Of course we're, you know,
7 behind schedule, but we'll figure this out.
8 The next presentation, which will take about an
9 hour, will be on the law of gun purchase and
10 possession, disqualification. We have Robin
11 Sparkman from the Florida Department of Law
12 Enforcement that's here. And after Ms.
13 Sparkman's presentation it will be 12:30. We'll
14 break for lunch at 12:30, and then we'll take a
15 look at the schedule for this afternoon. So,
16 Ms. Sparkman, welcome.

17 MS. SPARKMAN: Thank you. Thank you for
18 having me. I appreciate the opportunity to
19 come and share this information with you guys.
20 I am the Chief of the Firearm Eligibility
21 Bureau, which is a division of the Florida
22 Department of Law Enforcement. We process the
23 background checks for firearms that are
24 purchased from federally licensed firearm
25 dealers in the State of Florida to non-licensed

1 individuals as is required by Florida Statute
2 790.065.

3 Our mission is twofold. The first is to
4 go ahead and quickly process those background
5 checks so that law abiding citizens who are
6 eligible to receive those firearms can do so in
7 an expeditious manner. And then the second
8 part of that mission is to prevent those
9 transfers to individuals who are prohibited by
10 state or federal law.

11 The legislation that, that we are based
12 upon is, there's not a lot. It's actually very
13 minimal. The National Firearm Act of 1934 was
14 the first law. It's a federal law to regulate
15 firearms in the United States, and it came
16 about in the days of the gangland violence, and
17 really regulates automatic, automatic machine
18 guns, automatic firearms, short barreled
19 rifles, short barreled shotguns, and that type
20 of firearm. And its authority is limited to
21 those.

22 The firearm legislation that really made
23 the biggest impact and carries forward in today
24 is the Gun Control Act of 1968, and that Act
25 created categories of prohibited individuals,

1 and that's what we really base our background
2 checks on today. That Act was passed in the
3 wake of several high-profile assassinations,
4 John F. Kennedy, Robert Kennedy, and Martin
5 Luther King, Jr. Florida Statute 790.065 came
6 about after that in the late '80's, and in 1991
7 the Firearms Purchase Program stood up and
8 actually began doing automated background
9 checks.

10 So, the Gun Control Act basically said if
11 you are, if your record reflects that you are
12 this type of prohibited category, if you fit in
13 this type of prohibited category you aren't
14 allowed to purchase or possess a firearm,
15 however it was kind of the honor system. The
16 form was handed to the customer, the customer
17 filled out the form, and if they said they
18 weren't a convicted felon and signed on the
19 bottom of it then the firearm transfer
20 proceeded. It wasn't until the actual
21 background checks began in the late '80's here,
22 in the early '90's here in Florida, that we
23 actually began checking those answers against
24 the databases that we have access to.

25 And in 1993, the Brady Handgun Violence

1 Prevention Act was passed, and that became a
2 mandate state, or national, a national mandate
3 which was enacted in November of 1998. So,
4 Florida was well ahead of the curve on that
5 one.

6 There is a different between the laws that
7 oversee purchase and the laws about possession
8 of firearms. In federal code it's a little bit
9 easier to follow United States Code 922(g)1-9,
10 both, ban both purchase and possession of the
11 firearms if you fall, if you're a type of
12 category or person that falls under those laws.
13 922(n) as it's called bans purchase but not
14 possession of previously owned firearms.

15 In Florida we're a little bit more
16 disparate and across the board. 790.065 is
17 sale and transfer of firearms and tells us what
18 we can and cannot do while we're conducting the
19 background check and gives us the authority to
20 do our work there. And then there are
21 individual statutes, some of which were created
22 by the Marjory Stoneman Douglas Public Safety
23 Act, that address possession of firearms. So,
24 it's a little bit, a little bit more disjointed
25 in Florida law.

1 We also have some other laws that guide
2 our activities, which is 790.335 which prevents
3 the government from creating or maintaining a
4 list of legal firearm owners, and there is a
5 federal mandate for that also, the Firearm
6 Owner's Protection Act.

7 This list is the list of federal
8 prohibitors. These are the categories of
9 people who are prohibited from purchasing or
10 possessing a firearm according to federal law.
11 Most of the public will be glad to tell you
12 they know the first one, which is the felony
13 conviction one, but the other ones are a little
14 bit less well known, but when a transaction
15 comes into our center for a firearm background
16 check we look at all of these, and not just the
17 felony conviction, fugitive from justice,
18 unlawful user of controlled substance, of
19 course the mental health disability is a high
20 profile topic, illegal alien, dishonorable
21 discharge, renounced United States citizenship,
22 respondents to protection orders, convicted of
23 misdemeanor crimes of domestic violence, and
24 under indictment or active information for a
25 felony.

1 Our state disqualifiers are expanded on
2 the federal disqualifiers, so state law gives
3 us the ability to also screen background checks
4 against some juvenile crimes that were
5 committed, an adjudication of delinquency on a
6 crime that would be a felony if committed by an
7 adult will prohibit an individual until they
8 reach age twenty-four, or until that crime is
9 expunged from their criminal record.

10 We expand on the number of protection
11 orders we can deny on. Federal law covers
12 domestic violence protection orders only.
13 State law expands the definition of what
14 domestic violence is to the state definition
15 and adds into that other types of protection
16 orders. If an individual in Florida receives
17 adjudication withheld on a felony or a
18 misdemeanor crime of domestic violence they are
19 prohibited from purchasing a firearm until
20 three years has passed since the completion of
21 their sentencing provisions. So, if they were
22 assigned to do two years of probation following
23 their adjudication withheld they must complete
24 that two years of probation and then an
25 additional three years before they become

1 eligible to purchase a firearm in Florida. And
2 then there are a list in the statutes spelled
3 out of enumerated offenses, that while those
4 enumerated offenses have not been yet disposed
5 in court the arrest alone is sufficient to
6 prohibit the transfer of a firearm.

7 I'll talk just a minute about the mental
8 health prohibition. It is, it applies to those
9 individuals who have been to court and have
10 been adjudicated by a court as mentally
11 incompetent or ordered to treatment by the
12 court. This also applies to individuals who
13 are deemed mentally incompetent to proceed in a
14 criminal process, or who have been deemed not
15 guilty by reason of insanity.

16 It does not apply to persons who recognize
17 that they are suffering from a mental illness
18 and voluntarily seek treatment, and remain
19 voluntary through the treatment process, no
20 court order mandating them, they voluntarily go
21 through the process. It is also not
22 prohibiting for people who are Baker Acted,
23 held for observation, and then released at the
24 end of that observation period without a court
25 order. And a physician diagnosis alone, a

1 physician saying I believe this person is, is
2 mentally ill, and suffers from a mental
3 illness, without going that extra step and
4 getting that court order then the physician's
5 diagnosis alone is also not prohibiting.

6 When the determination is made by the
7 court, and recorded by the Clerk of Court, the
8 Clerk of Court submits that order to use
9 electronically through a web application called
10 MECOM, or the Mental Competency Database. They
11 have thirty days within the adjudication to
12 report that order to FDLE. The person record
13 is created in MECOM, and then it is, MECOM
14 interfaces with the NICS index, and the NICS
15 index is that system that's available
16 nationally, should that person travel outside
17 the state of Florida to purchase a firearm in
18 another state that information is then made
19 available through the NICS index to all other
20 states.

21 The only time remove someone from MECOM,
22 it takes a court order to get them in, it also
23 takes a court order to get them out. So,
24 individuals who are suffering through a mental
25 health crisis can recover, get better, their

1 doctor could say they're better, they could
2 petition the court to have their rights
3 restored, and if the court deems that they are
4 no longer a threat to public safety then the
5 court can restore their rights, and they would
6 be removed from MECOM, and removed from the
7 NICS index.

8 New to us in the Marjory Stoneman Douglas
9 Public Safety Act is the risk protection order,
10 so that was -- as I understand it the spirit of
11 the law was such that there are these
12 individuals who are Baker Acted, during their
13 time of observation they are released without a
14 court order, without being held, and yet they
15 still in the minds and judgment of the law
16 enforcement officials who took them to the
17 Baker Act facility remain a danger to public
18 safety. And this risk protection order is the
19 mechanism that the legislature has given those
20 law enforcement agencies to petition the court
21 to take the firearms away from this person and
22 make them ineligible to receive another firearm
23 during the length of the risk protection order.

24 A law enforcement agency is the petition
25 in this type of order. It is, can be issued

1 ex- parte, without a hearing, so that's a
2 temporary order, and then upon a hearing a
3 final order can be issued for a period of up to
4 twelve months. Before the twelve months is up,
5 the law enforcement agency can petition for an
6 extension for another twelve months, and the
7 respondent can petition to have the order
8 removed.

9 If an individual with a risk protection
10 order attempts to purchase a firearm, and we
11 process that background check, we call that law
12 enforcement agency that is the petitioning
13 agency and make them very much aware of what
14 has happened. That has only happened once
15 since this law is enacted, and it's in your
16 county, Sheriff Judd.

17 It prohibits possession in addition to
18 prohibiting purchase of a new one, so this is
19 one law that applies to both purchase and
20 possession. It requires the surrender of any
21 firearm that that individual has on them at the
22 time, and they may also voluntarily surrender
23 any other firearms they may have at their home
24 or in their vehicle. Law enforcement may seek
25 a warrant to seize additional firearms if they

1 do not voluntarily surrender them, and at the
2 end of the order, time of the risk protection
3 order, then the firearms are returned to that
4 person pending, only after a background check
5 has been done and that background check
6 indicates that that person is eligible to
7 receive them.

8 When we do background checks we get, you
9 get one of two decisions out of FPP, and that
10 is either an approval, there is no record that
11 indicates that person is un-eligible to
12 receive, therefore the purchase or the transfer
13 may go forward, or they get a non-approval,
14 which means that they, that there is a match to
15 a record which contains a prohibiting event or
16 arrest, and that individual is ineligible to
17 receive a firearm, and therefore they are not
18 approved.

19 There is a status that's somewhere in
20 between, and that is what we call a decision
21 pending. Sometimes we'll pull up a criminal
22 record, or we'll look at a criminal justice
23 information system and there is a piece of
24 information that may be missing. For instance,
25 perhaps they were arrested, and they went to

1 court, but the court disposition was not
2 reported back to the system, it may be a very
3 old record. We put a decision pending on that,
4 the transfer is kind of held in abeyance until
5 the research is completed, we find that piece
6 of missing information, and we can either make
7 an approval or a non-approval decision.

8 Some other changes that SB7026 had on our
9 operations is it changed the age limit from
10 eighteen to twenty-one for the purchase of a
11 firearm, for any firearm, including long guns,
12 with certain exceptions. It extended the
13 state- wide waiting period for all firearms to
14 three days. Previously that was only on
15 handguns, and now it also applies to long guns.
16 And it created the risk protection order as a
17 mechanism for law enforcement.

18 I want to talk just briefly about this
19 term that gets thrown a lot called the gun show
20 loophole and explain exactly what that is so
21 that we're all talking about it on the same
22 level playing field. A federal firearms
23 licensee, an FFL which is licensed by the ATF
24 to conduct business as a firearms dealer is
25 required to do a background check regardless of

1 where he or she is standing when that firearm
2 is transferred. So, if they're in their bricks
3 or mortar store, or if they're at their home,
4 or if they're at a flea market, or a community
5 center, or an arena, or a gun show in any
6 location they are required to do the background
7 check before they transfer that firearm to an
8 unlicensed individual.

9 No background check is required when an
10 individual who is not an FFL transfers a
11 firearm, so a private collector for example.
12 Say it's an individual who owns fifteen or
13 twenty firearms, and they're a collector,
14 they're an enthusiast, there are three or four
15 that they want to get rid of because they now
16 have their eye on three or four more they'd
17 like to buy, so they go to one of these
18 exhibitions, or arenas, or county fairgrounds
19 that's hosting a gun show, they rent a table
20 from the gun show coordinator, and they sell
21 their private collection at that gun show.
22 Those firearms are not required by law to have
23 a federal background check, or a background
24 check like a federal licensee has to do.

25 So, the question becomes then is that

1 person a private collector or is, or are they a
2 firearm dealer, and there is a book written by
3 the AFT that tells you whether they are or not.
4 And I would not be the authority on that, so we
5 would, we don't make that call at FDLE, that is
6 an ATF question.

7 The Florida Constitution, however,
8 provides that counties may enact an ordinance
9 that requires a background check when the sale
10 occurs on property to which the public has the
11 right of access. And that is -- the intention
12 of that, the spirit of that is to close that
13 loophole, if you will, where private sellers
14 are side by side, table next to table with
15 FLLs, and they're selling their firearms, and
16 that individual who knows he or she is
17 disqualified walks into that gun show where
18 they know there will be private sellers and
19 looks and says, oh, that's an FFL, I can't buy
20 gun there, here's a private seller, I'll go to
21 this private seller and I'll buy my gun there.

22 So, the county ordinances are meant to
23 close that loophole, and say even if you're a
24 private seller at one of those events you must
25 do a background check before transferring a

1 firearm, and those background checks have to be
2 facilitated by a federal firearms licensee, or
3 an FFL. That same constitutional amendment
4 allows for counties to also extend that three
5 day waiting period up to five days.

6 This is a map. I had to modify it a
7 little bit from what I provided earlier because
8 Alachua County passed an ordinance just
9 recently. There are ten counties that have
10 ordinances that either require the background
11 checks on the property which the public has the
12 right of access or extend the waiting period.
13 The counties in blue have a three-day waiting
14 period with a county ordinance, and the
15 counties in gold have a five- day waiting
16 period with their county ordinance. These
17 ordinances are enforced by the counties by code
18 enforcement, by the deputies. They are not
19 enforced by ATF or by FDLE.

20 And I'll be glad to answer any questions.

21 CHAIR: Commissioners, anybody have
22 questions? Okay, I do. Would you go back for
23 a second to Slide 4, I'm sorry Page 4. I just
24 want a clarification --

25 MS. SPARKMAN: Which is which one, I'm

1 sorry?

2 CHAIR: It's the juvenile one, so Page 4.
3 It's Page 4 in my book, I'm sorry. It's the
4 one on state qualifications, disqualifications,
5 and you talked about juvenile prohibitions,
6 where they're disqualified. It says with
7 juvenile prohibitions until age twenty-four or
8 until expunged. So, does that mean that if you
9 take a juvenile, and there's a petition for
10 delinquency, and they are determined delinquent
11 because it's a, let's say, a robbery let's say,
12 and they were sentenced through the juvenile
13 system and the judge found that they were
14 delinquent, for that fourteen year old, so does
15 that mean that that person is then prohibited,
16 because it's a felony, prohibited from
17 purchasing a firearm until age twenty four, but
18 at age twenty five they can go purchase a
19 firearm?

20 MS. SPARKMAN: That's correct.

21 CHAIR: Okay. And if the record for some
22 reason is expunged earlier than that then that
23 eliminates the firearm disability.

24 MS. SPARKMAN: Correct.

25 CHAIR: Okay. And so, but it only applies

1 to those offenses that are disqualifying, so
2 let's say at age thirteen is that the kid is
3 arrested for vandalism, is that at age
4 nineteen, or make it easier, at age twenty-two
5 they wouldn't be disqualified for purchasing a
6 gun.

7 MS. SPARKMAN: That's correct.

8 CHAIR: So, it still has to be the felony,
9 and the only different is, is that if you are
10 adjudicated of a felony as an adult is, is that
11 that prohibition stays in place unless
12 something removes that disability.

13 MS. SPARKMAN: That's correct.

14 CHAIR: But it's an automatic removal of
15 disability at age twenty-four or expungement
16 for juveniles.

17 MS. SPARKMAN: That's correct.

18 CHAIR: And I just want to make sure that
19 we're all on the same page with this. There
20 are -- as it relates to the Baker Act, and
21 we're going to hear from Judge Leifman this
22 afternoon about the Baker Act and its
23 requirements. There are roughly about a
24 hundred ninety-two thousand Baker Acts on an
25 annual basis in the state of Florida. The

1 absolute majority of them are somebody taken
2 into custody for an involuntary examination,
3 period, and anybody that is taken into custody
4 for an involuntary examination, whether it's by
5 law enforcement, whether it's by a mental
6 health professional, or anybody that is Baker
7 Acted and taken to a receiving facility for an
8 examination, under no circumstances does that
9 Baker Act, and that taking into custody affect
10 their ability to buy or possess or own a
11 firearm.

12 MS. SPARKMAN: Not alone.

13 CHAIR: Right, alone, that's what I'm
14 talking -- well, and prior to February 14th, or
15 put it this way, prior to March 9th when the
16 Governor signed SB7026 is, is that there was no
17 risk protection order mechanism in place,
18 right?

19 MS. SPARKMAN: That's correct.

20 CHAIR: Right. So, on February 1st of
21 this year if somebody was Baker Acted because
22 they're a danger to themselves or others, they
23 were taken to a receiving facility, they were
24 kept for eight hours and released, there was no
25 mechanism available to law enforcement to then

1 prohibit that person from purchasing a firearm.

2 MS. SPARKMAN: That's correct.

3 CHAIR: But today because of 7026, and
4 because of the risk protection order process,
5 the Baker Act itself still is not a
6 disqualifier, but law enforcement can petition
7 the court for a temporary, and then a final,
8 and for up to a year, with a year extension,
9 that person can be disqualified from purchasing
10 or possessing a firearm.

11 MS. SPARKMAN: That's right. The behavior
12 that initiate, that caused the law enforcement
13 officer to initiate the Baker Act could be the
14 foundation for the risk protection order.

15 CHAIR: Right. Exactly. So, and that's
16 the landscape today, but prior to 7026 a Baker
17 Act, and still today, a Baker Act in and of
18 itself does not disqualify somebody from
19 purchasing or possessing a firearm.

20 MS. SPARKMAN: That is correct.

21 CHAIR: And so, in the, in the mental
22 health arena in order to be disqualified from
23 purchasing or possessing a firearm it requires
24 an actual adjudication, you have a few other
25 examples in there, but an adjudication by a

1 judge.

2 MS. SPARKMAN: Right, the individual is
3 afforded due process.

4 CHAIR: So, I just want to make sure,
5 because there's a lot of misconception I know
6 in the public on that is, is that if you ask
7 the majority of the people in the community is
8 the absolute majority of the people believe
9 that somebody who is Baker Acted, that that
10 effects their ability to buy or possess
11 firearms, and that is absolutely not the case.
12 And -- and it's been stated, you know, in this
13 situation, that if Cruz had been Baker Acted he
14 wouldn't have been able to buy that AR and
15 that's erroneous.

16 MS. SPARKMAN: Right, it is a huge
17 misconception.

18 CHAIR: All right, anybody -- Senator
19 Book.

20 SEN. BOOK: Thank you, Mr. Chair. And --
21 and perhaps this is something that Judge
22 Leifman can expound upon, but do you know how
23 difficult it is to be adjudicated mentally
24 incompetent by a court? Is it a difficult
25 standard?

1 MS. SPARKMAN: I think Judge Leifman would
2 be the right person to comment on that.

3 SEN. BOOK: Okay, I'll save my questions
4 for Judge Leifman. Thank you.

5 CHAIR: Anybody else, any other questions
6 for Ms. Sparkman? Okay.

7 MS. SPARKMAN: Thank you.

8 CHAIR: Thank you very much. All right,
9 the next presentation is going to take some
10 time. We have it scheduled for an hour and a
11 half, and it's an overview of the mental health
12 system by Ute Gazioch from DCF, and that's the
13 presentation, that's one that we had to move
14 from last time to this time. And it is now, I
15 said we were going to break at 12:30. I
16 thought that this presentation and questions
17 might take a little longer. I don't want to
18 start the next one because it will take us well
19 into 1:00 or 1:30 before we're finished with
20 that.

21 Lunch will be ready in about ten minutes,
22 so why don't we -- I got about ten minutes to
23 12:00 now. Lunch will be ready at noon, about
24 ten minutes from now, so why don't we try, why
25 don't we be back here, I'll give you what we

1 did yesterday, I think it worked, forty-five
2 minutes, so why don't we be back here, we'll
3 start again at 12:45 with Ute's presentation,
4 and then when we come back at 12:45 we'll
5 discuss the schedule for the rest of the day.
6 I think we're going to have to drop off some
7 things at the end of the day because otherwise
8 we won't get out of here until 7:00, and I know
9 people have travel and everything else.

10 So, let me look at the schedule, we'll
11 come back and talk about the schedule we begin
12 with her presentation. But we'll break now.
13 Lunch will be ready in a couple minutes. And
14 we'll start again at 12:45.

15 (Thereupon, a recess was had, and the meeting
16 continued as follows:)

17 CHAIR: Okay, we'll go ahead and get
18 started with this afternoon's presentations.
19 So, as we've done with the other topics we're
20 going to start with a broad perspective of
21 Florida's mental health system, and then kind
22 of gradually bring it down to Broward County
23 level, and then eventually into the specifics
24 of what happened here, is Cruz's involvement
25 with the mental health system. So, we're going

1 to begin with the presentation from DCF, and
2 Ute Gazioch is here from the Department of
3 Children and Families to give us an overview of
4 Florida's mental and behavioral health system.
5 Welcome.

6 MS. GAZIOCH: Thank you.

7 CHAIR: Thank you for being here.

8 MS. GAZIOCH: Thank you, Chairman
9 Gualtieri, and members of the commission for
10 having me. Today I will be speaking with you
11 from a very high level about Florida's
12 behavioral, community behavioral health system.
13 And what that means in our terms is it includes
14 the services that are available to our
15 community members who have either a mental
16 illness or a substance use disorder. So, I
17 will not be addressing any of our state
18 hospitals which cannot just be accessed by
19 community members, those require court
20 proceedings.

21 To give you kind of a very, very high foot
22 overview of mental illness is that it is a
23 medical condition. It can disrupt a person's
24 thinking, the way people feel, a person's
25 moods, their ability to relate to others, as

1 well as their ability to function on a daily
2 basis. There are hundreds and hundreds of
3 diagnoses that make up mental illnesses within
4 our community mental health system, especially
5 our publicly funded community mental health
6 system. We usually encounter individuals who
7 have what we call a serious mental illness, and
8 those are usually grouped into categories such
9 as major depression, schizophrenia, bi-polar
10 disorder, basically those illnesses that affect
11 a person's ability to function in the
12 community.

13 Mental illness strikes men and women at
14 about the equal rate, and it does not
15 discriminate in terms of socioeconomic
16 background, gender, ethnicity. Basically,
17 anybody can have a mental illness. There are
18 many things that affect the way our brain
19 works. There's genetics. There's
20 environmental causes, such as stress and
21 trauma. And again, environmental factors such
22 as stress and trauma, lifestyle, as well as
23 biochemical issues in the brain. I think it's
24 important to also distinguish that there are
25 many different brain conditions that are not

1 necessarily all mental illnesses. And I think
2 we have a tendency to lump those things
3 together, but just to be clear there are other
4 things that affect brain functioning, like a
5 traumatic brain injury, which would not be
6 considered a mental illness.

7 There are also developmental disorders
8 that often get grouped into mental illnesses,
9 such as autism spectrum disorders. They would
10 not, also not necessarily be considered a
11 mental illness. And it's important to make
12 that distinction because the way that we want
13 to treat those conditions are all very
14 different, and they respond to different
15 interventions, medications, and so forth.

16 To give you an idea of the prevalence of
17 behavioral health conditions approximately
18 eighteen percent of the general population has
19 a diagnosable mental illness. Again, that can
20 be any mental illness, so when you hear that
21 one in five that's what they're talking about,
22 about one in five individuals has a mental
23 illness. Again, that's not necessarily a
24 serious mental illness. When you start talking
25 about a serious mental illness those numbers go

1 down pretty drastically, and we talk about one
2 in seventeen, which comes out to just a little
3 less than six percent of the population.

4 About twenty million Americans had a
5 diagnosable substance use disorder last year,
6 and about eight million had both a mental
7 illness and a substance use disorder, so you
8 often encounter individuals who have both
9 mental health as well as substance use
10 conditions.

11 In terms of children, children have, there
12 are some diagnosis that can be used for both
13 adults and children, then there are some
14 diagnosis that are specific to children. They
15 are called, you know, conditions of childhood.
16 And then there's some diagnosis that we
17 typically don't use until after the age of
18 eighteen. But it's estimated that about
19 thirteen to twenty percent of all children have
20 a mental disorder, and we know that most mental
21 illness starts by age fourteen.

22 So, I know in the pervious presentations,
23 one of the themes that I heard over and over,
24 which I'd like to also stress, is that it is
25 very important that we, we screen for

1 behavioral health conditions early, because
2 like most other illnesses, and chronic
3 illnesses, the earlier we can detect something,
4 intervene, and treat, the better the trajectory
5 is for that person over a lifetime.

6 I want to also talk about stigma of mental
7 illness just a little bit, because I think it
8 has a huge impact on how people seek treatment,
9 and how they often try to hide their
10 conditions. People think that if they have a
11 mental illness that they are crazy, and that
12 people will label them as crazy. You know,
13 there's two thoughts of school, there's a
14 school of thought that thinks mental illness is
15 not a real thing, people are faking it, they're
16 making it up, and if they just wanted to, they
17 could fix their behaviors. And then there's
18 another group that thinks once you have a
19 mental illness you can never recover, that's
20 it, we should just lock folks up and throw away
21 the key. And really none of those are
22 accurate.

23 A lot of folks also think that children
24 don't suffer from mental illnesses, but they
25 do. And for the most part, you know, I think

1 it's a human condition that we often lack
2 inside, so most of think that it would not be
3 something that would happen to us. And I think
4 that's important to consider because I think
5 that stigma has a huge impact on persons
6 readily seeking treatment. It's something that
7 they hide. It's something that families hide.
8 You know, there was discussion the other day
9 about parents' responsibility in this. Again,
10 a lot of parents feel isolated if, if they
11 think their child has a mental illness, so
12 because of that stigma, and that shame, it
13 really leads to people not finding treatment,
14 and working with treatment providers.

15 To give you an overview of our legislative
16 authority I'm going to be specific to mental
17 health on this. We are governed by Chapter 394
18 of the Florida Statutes. The first part of
19 that is probably the part that you are all most
20 familiar with, which is the Florida Mental
21 Health Act, also known as the Baker Act. This
22 is the main legislation that authorizes the
23 Department to designate our local community
24 providers to receive people who have been, who
25 are brought in involuntarily for an

1 examination. And we often call that being
2 Baker Act.

3 There's also sections that specifically
4 address guidelines for children's services, as
5 well as community adult services, and then also
6 involuntary commitment of sexually violent
7 predators. But we won't get into that today,
8 we'll kind of stay in parts 1, 3 and 4. Those
9 statutes outline the functions of DCF. We are
10 the designated State mental health substance use
11 and methadone authorities, which gives us the
12 responsibility of writing administrative code,
13 as well policy in regards to systems.

14 We also designate any facility that would
15 be able to receive a person on an involuntary
16 status. That includes addiction receiving
17 facilities, crisis stabilization units, and
18 also private hospitals who have psychiatric
19 units. We allocate our state and federal funds
20 to seven contracted behavioral health managing
21 entities. These are the agencies that are
22 responsible in their geographic area to
23 contract with private providers who actually
24 provide any of our prevention, treatment, and
25 recover services.

1 And I want to -- one of the things that I
2 want to really bring across today, that this is
3 only part of the behavioral health system. The
4 managing entities are the folks who contract
5 with agencies with our state dollars, and those
6 are general revenue dollars, those are federal
7 block grant dollars, but there are multiple
8 ways that behavioral health services are paid
9 for that are not all necessarily within this
10 structure.

11 So, for people, for example, who have
12 Medicaid, you know, they would not be funded
13 through the managing entities. Individuals who
14 have private insurances would not necessarily
15 go through the managing entities unless they
16 needed a service that those plans would not pay
17 for, then the managing entity could fill those
18 gaps. So, basically, what we provide is the
19 safety net. We provide services for those
20 individuals who are indigent, or who are under
21 insured, or not insured at all. And to, to
22 ensure that, you know, folks that can afford
23 care we work on a sliding scale system.

24 So, as I said earlier the Department, we
25 also promulgate rule, as well as policy, and we

1 are also the licensing entity for all substance
2 abuse services. The managing entities were
3 established in statute in 394.908(2). We were
4 fully implemented around 2012, so depending on
5 how you look at it, I look at it as it still
6 being fairly new, but some people might say
7 they've been around for a while. I think, you
8 know, we're still in that, in that process of
9 all, you know, from the Department having had
10 hundreds of contracts to moving to managing
11 entities it's been a, it's definitely been a
12 process. But I think we're finally in a place
13 where our managing entities, you know, really
14 have a grasp of their system of care, and are
15 starting to ensure that, that those gaps are
16 being filled.

17 They are nonprofit corporations, and they
18 are the ones that manage the day to day
19 operations of that behavioral health care
20 system. And just this gives you an idea where
21 the seven managing entities are. And Broward
22 is actually the only place where a managing
23 entity does not facilitate services in one of
24 our working regions. Broward actually has
25 their own managing entity, Broward Behavioral

1 Health Coalition. And I know that you'll meet
2 that CEO, I think later, Ms. Sylvia Quintana.

3 In terms of again the populations we serve
4 there is that factor of, of not being able to
5 pay for your care, or your care not being
6 covered by one of those insurance plans. We do
7 concentrate primarily on those individuals who
8 have a serious mental illness. Those priority
9 populations are outlined in statute. In terms
10 of children it's a lot more broad. We can
11 serve children who are at risk. We can serve
12 children who have an emotional disturbance, and
13 those who have a serious emotional disturbance.
14 And then obviously individuals who have
15 substance use disorders or are at risk.

16 We do have priority populations within
17 that. Obviously when you work within limited
18 resources you do have to at times prioritize,
19 and for that, for those purposes our priority
20 populations are pregnant women and parents with
21 substance use disorders, obviously because of
22 the risk that substance use conditions pose on
23 small children. And we also very much focus on
24 intravenous drug users, obviously also because
25 of the potential of, of death and overdose, and

1 so forth, to give you an idea of how many
2 people we serve, last fiscal year almost three
3 hundred ten thousand people were served through
4 our managing entities, and then below that
5 you'll see a breakdown in terms of mental
6 health substance abuse adults and children.
7 Don't try to add those up, they will not add up
8 to three hundred nine because folks can move
9 between areas. So, if a child turns eighteen
10 and moves in to the adult system they were
11 counted in the adult system and in the
12 children's system. But the actual distinct
13 number of people served is that three hundred
14 nine thousand four hundred fifty- one. So,
15 again, this is not all the people in Florida
16 that receive behavioral health services, this
17 is only the number that the managing entity has
18 served.

19 In terms of budget you'll see that our
20 community behavioral health budget for last
21 year was just over \$720 million. A little over
22 five percent of that goes to operations, and
23 that includes DCF's operations as well as the
24 managing entity operations. That also includes
25 things that we don't consider services, such as

1 training, the Baker Act reporting center, which
2 is where the Chair got his numbers earlier in
3 terms of the number of Baker Acts, which last
4 year were actually, went up a little bit, and
5 were about around a hundred and ninety-nine
6 thousand, the examinations that were initiated.
7 And then you can see what our funding is across
8 the state, and you'll see that Broward received
9 just a little over \$57 million for their
10 services.

11 Again, there are multiple funders which
12 the behavioral health system, which makes it a
13 very complex system, especially because people
14 don't necessarily fall into the funding stream
15 that they are. So, if you have a child with a
16 serious emotional disturbance and they need
17 very intensive in-home care, parenting support,
18 and you have private insurance, it is very
19 unlikely that your private insurance is going
20 to pay for that level of care. So, it becomes
21 very complicated at the provider to keep all
22 this straight, because most of the providers
23 within our network are, they have some of their
24 funding through us, through DCF. A majority of
25 them are Medicaid providers, so they accept

1 Medicaid. You know, some may take all of the
2 plans, some may take some, and then there's
3 also private insurance considerations.

4 Some counties have county funding that
5 they fund programs with. Some counties have
6 children services councils. Some people get
7 grants from private organizations. So, in
8 terms of funding perspective it's, it's all
9 these fund sources, and the providers piece
10 together all these buckets of money, and then
11 try to provide whatever is needed in that
12 community.

13 In terms of access, especially for
14 children a lot of referrals come through
15 pediatric settings. If those pediatricians do
16 thorough screenings and have referral
17 relationships with providers. Also, many
18 people with behavioral condition get all their
19 care through their primary care physician. So,
20 we talked a little bit earlier about twenty
21 percent of the population having a mental
22 illness, and then we looked at the three
23 hundred and ten thousand that were served, and
24 clearly there's a lot of people who have a
25 mental health diagnosis who are getting their

1 treatment in a pediatric setting. There are
2 also many who never ever get treatment for
3 their behavioral health conditions.

4 But pretty much our goal is to have an
5 open- door referral process where it does not
6 matter where the referral comes from, that
7 wherever folks are calling, that that place
8 will actively connect people to where they need
9 to go. I think that's an area that we can
10 definitely do a lot better in, but that is the
11 goal, that if folks need help that they have a
12 place to go, and they're not being told, oh,
13 sorry, we don't take that insurance, and then
14 it's just a click. That -- that we care,
15 coordinate, and get folks to the places that
16 they need to go.

17 In terms of the community service array,
18 it looks very similar between the adult system
19 and the children system, and if I had a pointer
20 I would put a little imaginary line between the
21 CSU and the State treatment facilities, because
22 really what we consider the community system
23 kind of stops at the CSU level. So, we start
24 with prevention services. For substance use,
25 there's actually evidence-based programs that

1 our managing entities fund in the school
2 systems, or with our anti-drug coalitions to
3 provide prevention services for substance use.

4 On the mental health side, we talk more
5 about behavioral health promotion, and wellness
6 promotion, and talking to families when their
7 kids are very young about how they can help
8 their children have social and emotional, what
9 we call social and emotional health, meaning
10 they're able to socialize with others, they're
11 able to manage their emotions, their anger,
12 their disappointment, and so forth.

13 In terms of if a child does need treatment
14 the lowest level of care is outpatient, and
15 that's typically bringing your child to a
16 therapist in a, in a therapist's office,
17 whether that's a private therapist or within
18 one of our community behavioral health
19 providers. That can also include medication
20 therapy, seeing a doctor. If a child requires
21 more intervention than that we start going to
22 the community support model where we're doing
23 in home visits, and really our goal is to
24 ensure that we are meeting the family where
25 they're at, so you'll see -- and Henderson has

1 always done this, where there are in-home
2 programs, literally they'll go to people's
3 homes at 6:00 at night, they'll go to homes at
4 weekends. They'll -- they'll do basically
5 whatever it takes to make it as easy for that
6 family to be able to receive those services,
7 because, you know, families have lives. They
8 have to go to work, and those hours don't
9 always match with, with outpatient type hours.

10 For children specifically, we've also
11 implemented community action teams throughout
12 the state, which are very intensive in-home
13 services. And one of your commissioners is
14 actually the creator of that model. That
15 started, when did it start, about five years
16 ago with a few teams, and with the funding this
17 year we'll be able to scale that up to forty
18 teams across the state. So -- and basically
19 those are self-contained teams that included a
20 psychiatrist, therapist, case manager, flexible
21 funding, to wrap that family as tight as
22 possible to provide whatever they need when
23 they need it, twenty four/seven access, coming
24 to the home to hopefully provide that family
25 the support to learn how to work with their

1 child within that setting. Because residential
2 setting, you know, are important, and that's
3 the next highest level, but unfortunately what
4 happens is children get better, and then they
5 return to the same exact environment that they
6 came from, and nobody has really worked with
7 that family.

8 And you'll see the adult system works very
9 similarly for adults. We don't have CAT teams,
10 but we have assertive community treatment
11 teams, those are our fact teams for, for folks
12 that probably wouldn't make criteria to be in a
13 locked state mental health treatment facility
14 but we're trying to keep them in the community.
15 Again, that twenty-four/seven access, somebody
16 is on call at all times, and can respond to the
17 home at all times.

18 And then we have our, in the community
19 setting our highest level of care, which are
20 in- patient beds and crisis stabilization units
21 for individuals who are in a mental health
22 crisis and need to be somewhere safe for a few
23 days, sometimes longer, and then hopefully will
24 be brought back to the community.

25 As I'm speaking about this I just, I just

1 want to make sure that we understand the
2 purpose of a crisis stabilization unit, because
3 it didn't just come with this tragedy, but for
4 a long-time people say, well, why weren't,
5 weren't they Baker Acted, they need treatment.
6 A crisis stabilization unit is not really
7 long-term treatment. It is literally what the
8 name says. It is a crisis stabilization. So,
9 if you have a person who is either an imminent
10 threat to another person or themselves you want
11 some place where they can be safe, they can be
12 evaluated, given medication, short term
13 counseling, so forth, but it's not a long-term
14 solution.

15 So, you know, I just don't -- I just don't
16 want anybody to think that people recover on a
17 CSU. Again, this is, these are chronic
18 illnesses that take long term treatment, long
19 term supports, and that is not what a CSU can
20 do. On the reverse, if folks are put on crisis
21 stabilization units that really don't need that
22 level of care you can do a lot more harm than
23 good. You can actually harm that person,
24 because as you can imagine they can be, most of
25 the time they're not, people think they're

1 scary places, but it is very unusual to see
2 people with a serious mental illness when you
3 don't have that serious mental illness, and you
4 are locked up with them for the next three or
5 four days.

6 CHAIR: While you're there will you just
7 explain the interplay between the receiving
8 facility and the CSU so that everybody has an
9 understanding of that?

10 MS. GAZIOCH: Sure. So, CSUs are usually
11 designated as a receiving facility, so in order
12 to receive somebody, or accept somebody for an
13 evaluation, you must be designated that, on an
14 involuntary basis, you must be a designated
15 receiving facility. So, when a law enforcement
16 officer, for example, and close to fifty
17 percent of all involuntary examinations are
18 initiated by law enforcement. The other half
19 usually is by the mental health professionals
20 who are licensed to do so, and just a little
21 less than two percent are initiated by the
22 courts.

23 So, the designated receiving facility
24 literally, I also think that's another
25 misconception, that people think that if

1 somebody has been, a Baker Act has been
2 initiated, that they're going to be admitted,
3 and actually the initial initiation is just for
4 the examination. So, that means you will take
5 them to a designated receiving facility and
6 they will be screened by a mental health
7 professional, looked at to see if they actually
8 meet that criteria.

9 If they do not meet the Baker Act
10 criteria, they will likely be released. In a
11 perfect world, in good practice they wouldn't
12 just be released to the street, there would be
13 care coordination, there would be services
14 followed up in the community, because logic
15 would dictate that even if you don't meet
16 criteria if you were taken there there's
17 probably some, you probably need some help.

18 There are always those outliers. I've
19 seen people brought in in custody cases where,
20 you know, one of the persons called the cops on
21 their wife because they wanted the kids, and
22 they wanted a Baker Act on the record. I've
23 had a kid dropped off because the parents were
24 going on vacation. I ruined their vacation
25 when I called them and said you need to come

1 back, he doesn't meet criteria. So, there's
2 always those strange outliers, but for the most
3 part if people are brought there it's for a
4 reason, and even if they're not admitted they
5 really should have some kind of follow up plan
6 that happens at the receiving facility.

7 So, the first thing that happens is that,
8 you know, initial assessment to see if that
9 person really meets criteria. Does that answer
10 your question, or did you want me to -- okay.

11 Okay, so in terms of Broward Behavioral,
12 again they are the managing entity in Broward
13 County that is funded to administer the safety
14 net of behavioral health services here. They
15 contract with a variety of behavioral health
16 providers, and they partner with many of the
17 community stakeholders. The fifteen-network
18 provider there is, is mostly mental health
19 providers. They actually contract with over
20 thirty, because they do, you know, there's also
21 substance abuse providers, peer coalitions,
22 other places that they, other providers that
23 they contract with that provide services.

24 Broward County actually is one of the more
25 robust counties in Florida in terms of funding

1 sources, and in terms of service array. I
2 actually grew up here, so this is the county
3 that I was used to, and the provider system
4 that I was used to, and when I moved up north I
5 was shocked to see how much we actually, you
6 know, we always complained in Broward that
7 there's not enough until I went somewhere else
8 and said I would never complain again.

9 So, Broward County has a number of
10 providers. Obviously, there's a lot of folks
11 who have commercial insurance here, folks that
12 are covered by Medicaid, Medicare. Broward
13 Behavioral Health Coalition is very ambitious
14 in terms of applying for additional grants to
15 bring other resources into the community. The
16 County has designated behavioral health
17 funding. Broward has a children's services
18 council that pays for, for things. And then
19 obviously there's always the other state
20 agencies. DJJ provides a number of behavioral
21 health programs to the juveniles that they
22 serve. The educational system, schools have a
23 certain level of therapists. And that's all a
24 good thing, but that can also create
25 challenges.

1 And again, one of the themes that I picked
2 upon in previous speakers is connecting those
3 dots. When you have so many entities providing
4 services you can start having silos, and then
5 the communication doesn't get shared. So, you
6 may have a therapist at the community
7 behavioral health center, and they're working
8 on things, you may have a school therapist that
9 you're seeing, they may not even know about
10 each other, or talk to each other, so that is
11 definitely one of the challenges that we have
12 in our behavioral health system, is silos
13 within systems that don't often, or, you know,
14 sometimes they do, sometimes they don't, but
15 the sharing of information and being able to
16 connect those dots becomes very different.

17 One of the other challenges I think that
18 we experience is that there are these arbitrary
19 lines between the children's system and the
20 adult system. We have the age of maturity,
21 which is eighteen, which makes somebody a legal
22 adult. It doesn't necessarily mean that
23 they're mature, or that they actually are an
24 adult, but the way that our systems look at it,
25 diagnosis differ, level of acuity differ. So,

1 you can have a seventeen- year-old who is in
2 services, has met medical criteria, definitely
3 needs to be there, and suddenly at eighteen
4 that diagnosis no longer makes them eligible
5 for adult services. So, we definitely have
6 issues around transitions.

7 Their service models differ. In the
8 children's world you have a lot of emphasis on
9 family-based programs, where in the adult world
10 we suddenly, we don't engage the family as much
11 as we do in the children's world. And there's
12 obviously developmental considerations. When
13 you talk about teenagers, eighteen-year olds,
14 you know, turn eighteen, you know everything,
15 you can fire your therapist, you don't have to
16 go to your program anymore, and they were wrong
17 anyway, you know, then that stigma comes in,
18 I'm not crazy, I don't have a mental health
19 issue, and we lose them.

20 And I think as a system it's our
21 responsibility to figure out how to better
22 engage this, this group of individuals, because
23 at the end of the day that's what we should
24 expect based on their developmental milestones,
25 and, you know, I think that's part of our

1 responsibility, and our job, is to engage, and
2 to build that trust and rapport, and make them
3 want to come back, and make them want to be
4 part of our, our programs.

5 And again, I think that brings us to some
6 of the keys of effectiveness. One of the most
7 important things that I think we need to think
8 about when we treat, whether it's children or
9 adults, is that we match the intervention to
10 what the need is. And that's difficult, and it
11 takes a lot of assessment, and it takes a lot
12 of thoughtful assessment, because I can show
13 you four people with the exact same diagnosis
14 and they'll all be on different medications,
15 and what worked for the first person absolutely
16 didn't work for the second, maybe worked for
17 the third a little bit, but you really have to
18 spend a lot of time looking at the function of
19 someone's behavior.

20 Behaviors will always have a function.
21 There's always a need. There's something
22 that's met with the behavior, and regardless of
23 diagnosis that's different for every kid. So,
24 I think we always talk in terms of programs,
25 and I heard a lot over the last few days that

1 magic wand, unfortunately there isn't a magic
2 wand, you really have to do the work, and you
3 have to assess well, and then you have to
4 figure out the motivation, how to engage that
5 individual, and then match that individual to
6 the right intervention at the right level.

7 Also, in terms of losing that
8 communication, and being able to connect that
9 dots, we really, one of the keys to
10 effectiveness is, is effective care
11 coordination, and having that one person that
12 has accountability for making sure that all
13 those other systems are talking to each other.
14 So, care coordination, case management, those
15 things are absolutely integral, because when
16 you start looking at kids who have serious
17 emotional disturbances, or adults with serious
18 mental illness, they never have just this one
19 issue, right.

20 They come in contact with the criminal
21 justice system, now they'll have either
22 probation or parole officers. They come in
23 contact, you know, they usually have issues at
24 school. Usually there are a lot of family
25 issues, so you may have child welfare engaged.

1 And again, if all those silos work separately,
2 you know, your chances of success are very low.
3 But if you have very good care coordination,
4 and you have people who connect those dots and
5 make sure that everybody on that team is at the
6 right, on the right page, and you're engaging
7 that child and their family in your decision
8 making to get their buy in, and their
9 engagement, your outcomes will likely be much
10 better.

11 And again, to not think that we cure
12 people, people get better, people definitely
13 recover. I'm willing to bet that everyone in
14 this room either works with somebody or knows
15 somebody that has a serious mental illness, and
16 you don't know, that they have that serious
17 mental illness, they function well, but, but
18 there needs to be ongoing support, and there
19 needs to be places that people can go to get
20 that support.

21 Again, those challenges, multiple issues
22 that overlap, it's never one thing, which also
23 means there's never just one answer. The silo
24 systems, communication, again different funding
25 types and different rules. What Medicaid

1 requires may not be what the state requires,
2 which is totally different than what insurance
3 requires, and, you know, if you're a parent
4 with a child that has special needs, or if
5 you're a person with a mental illness whose
6 frustration tolerance is probably not as high
7 anyway, these are very different systems to
8 manage, and again a care coordinator or case
9 manager can really help navigate that system.

10 An effective engagement, again it's
11 different, whether it's with, whether it's
12 stigma. When you start getting into more of
13 the adult diagnosis like thought disorders,
14 schizophrenia, and those things where people do
15 have paranoia, or they do have hallucinations
16 that tell them that you're the devil and you
17 really shouldn't talk to them, those are very
18 real for that person, and again that, that, you
19 know, we have to figure out how to engage those
20 people and make coming into treatment worth
21 their while.

22 I won't spend too much time on the Baker
23 Act because I know Judge Leifman will be here.
24 But again, the number one purpose of the Baker
25 Act when it was first conceived in the 1970's

1 was actually to protect individual's civil
2 rights. It provides for a place for persons to
3 have an assessment and stabilize, again, the
4 crisis. It's not long-term care. It should
5 really stabilize that crisis, and then help
6 navigate the community behavioral health system
7 for that person, so that they can go into the
8 community and have services in place almost
9 immediately, because the crisis is usually not
10 a hundred percent over once somebody leaves the
11 CSU, but they no longer meet that, you know,
12 that threshold that, that of an, of an
13 immediate danger.

14 It does say that we have to use the least
15 restrictive form of intervention, and it does
16 provide for voluntary and involuntary
17 examination and stabilization in in-patient and
18 out-patient settings. So, the law does allow
19 for out-patient orders as well, but they are
20 not widely used throughout the state. And
21 again, it is a constant balancing act between
22 somebody's rights and liberties, because it is
23 the only time that we allow somebody to be
24 locked up against their will when they have not
25 committed a crime. So, there is that balance

1 between their civil liberties and the safety of
2 the community, and the safety of that
3 individual.

4 Again, that criteria, it was discussed the
5 first day we were here, that number one, the
6 person does have to have a mental illness, so
7 that is kind of what everything else flows on,
8 you know, follows. So, it kind of makes sense,
9 for example if somebody is a threat to somebody
10 else, who has harmed somebody else, and they
11 don't have a mental illness, they should
12 really, they've committed a crime and they
13 should go to jail. So, that mental illness is
14 kind of that first threshold. Obviously for
15 police officers, there's no expectation that a
16 police officer would have to do a full
17 diagnosis and know, so it's basically a
18 reasonable suspicion that that person has a
19 mental illness.

20 Also, police officers, it's a little bit
21 different. They have a little bit more,
22 they're the only ones that can make the
23 determination based on witness statements,
24 whereas a mental health professional actually
25 has to hear and see the behavior that would

1 lead to their decision that the person meets
2 this criteria.

3 Again, the first step is always trying to
4 get that person into service voluntarily, or
5 see if willing family members, community
6 members can help, but if that person refuses,
7 or they're unable for themselves to judge, then
8 the Baker Act can be initiated.

9 There has to be a decision that without
10 that treatment that person is likely to suffer
11 from neglect, or refuse to care for themselves,
12 and usually you'll see that for person with
13 schizophrenia, or another psychotic disorder,
14 where they may not be harming themselves or
15 others but they haven't left their apartment in
16 two weeks, they haven't showered, they're not
17 eating, they may think their water is poisoned,
18 they may think their food is poisoned, so
19 clearly there is a serious threat to their
20 well-being because of their mental illness.

21 Or that there is a substantial likelihood
22 that without that treatment the person will
23 cause in the very near future serious bodily
24 harm to themselves or others. And again, there
25 should be recent behavior, and again law

1 enforcement can actually take statements from
2 family members and use that as evidence,
3 whereas a clinician really has to make that
4 determination themselves.

5 The involuntary examination period is up
6 to seventy-two hours. That's an important
7 thing to note, it's up to. If the person at any
8 point during that seventy-two hours no longer
9 meets criteria they have to be discharged. So,
10 that could happen after fifteen hours, sixteen
11 hours, or hour seventy-one. If the person
12 continues to meet criteria, the first thing a
13 receiving facility would do is ask that person
14 to sign in voluntarily. If that person does
15 not, when they refuse, and they still meet
16 criteria that receiving facility will initiate
17 a petition for involuntary treatment with the
18 courts.

19 Once they are filed, once that is filed
20 they can hold the person beyond the seventy-two
21 hours, and then there will be a court hearing,
22 at which point a judge will determine whether
23 criteria has been met. There has to be a
24 second opinion by either a psychologist, a
25 licensed psychologist, or another medical

1 doctor. So, again if, if they no longer meet
2 criteria they must be released. If -- if the
3 involuntary examination was initiated while the
4 person was in the process of committing a crime
5 they need to then be returned to law
6 enforcement, and again if not, they just need
7 to be released, or a petition has to be filed
8 with the court to keep folks longer.

9 Any questions about that, because I know
10 the Baker Act has been a hot topic?

11 CHAIR: You know, we'll have Judge Leifman
12 here in a little bit, and I'm sure he'll go
13 into it in great detail on the Baker Act, so.

14 MS. GAZIOCH: Okay. Okay, great. So,
15 what we'd like to see in the children's system
16 of care is that it's a coordinated network
17 between community providers, schools, juvenile
18 justice, primary care, that families, like I
19 said, are engaged, and that they drive their
20 treatment. They really need to be a part, and
21 an active member. They have a responsibility
22 in this, just like the provider does. That
23 it's culturally and linguistically competent.
24 That's another reason why we see drop out, or a
25 lack of engagement. If you don't speak the

1 person's language, it's difficult to engage or
2 do anything. And that we have an array of
3 services that really meets the need of, of the
4 people that we serve.

5 I think what we, what we do see a lot is
6 that we create programs, and then we try to fit
7 the people into the programs rather than
8 figuring out what that person really needs and
9 finding the services that, that they need. And
10 -- and I think that's where you see a lot of
11 drop out, because the person is not actually
12 getting what it is that they need.

13 So, again, that services are
14 individualized and least restrictive. Again,
15 you can do harm if you put people into a
16 service level that they're really not meant to
17 be in. That we meet the needs of young
18 children. I think also that is an area we can
19 do better in, again, that early screening, and
20 those early interventions, and facilitating
21 that transition to adulthood.

22 Again, the CAT programs I think have shown
23 great promise in working with kids,
24 specifically kids that have multiple issues
25 and, and serious emotional disturbances,

1 because they are team based, they are
2 completely family focused, so they're not just
3 working with the child and then returning that
4 child into a family that may not be very
5 functional. They work with the entire family.
6 They can work with siblings and uncles, the
7 more the merrier.

8 They have several professionals on the
9 team, but they also have paraprofessionals, so
10 they have peer mentors, and people that the
11 kids can talk to that's not therapy. And
12 again, the goal is to keep kids out of
13 residential treatment and keep them within
14 their family unit, and help that family unit
15 deal with that, that child, because that's
16 challenging, right, and your traditional
17 parenting may not work with a child that has a
18 serious emotional disturbance.

19 Other programs that we're introducing are
20 coordinated specialty care for early serious
21 mental illness, again trying to, especially for
22 individuals with schizophrenia trying to
23 identify young people. Usually schizophrenia
24 that first break is in the early twenties, and
25 we want to make sure that we catch those people

1 during that first break and intervene
2 immediately with the right medication, the
3 right peer supports, the right therapeutic
4 supports so that we can change that trajectory.
5 So, hopefully if we can keep that first
6 psychotic episode as short as possible,
7 intervene, those people are much more likely to
8 be successful and become a productive member of
9 our society.

10 And basically, Broward County has both of
11 those. As a matter of fact, the coordinated
12 specialty care team here in Broward County was
13 actually one of the first that was in the
14 original RAIS study, which is the study that
15 went on for multiple years to look at these
16 interventions and see how successful they are
17 for persons with their first psychotic episode.

18 Again, you know, I think our providers do
19 a lot of things well, you know, I think they're
20 constantly looking to engage folks better.
21 They're working with multiple funders, all with
22 different rules. I remember when I was a
23 provider my notebook was this thick of every
24 Medicaid plan, and all their different Medicaid
25 criteria, because one will accept this, the

1 other won't, people switch. I mean it's --
2 it's very complicated, so, and their working
3 with limited resources. But we certainly
4 always have to look at our opportunities for
5 improvement.

6 Again, timely access to care, meaning a no
7 wrong door, especially for people coming out of
8 CSUs, because if somebody is coming out of a
9 CSU and their first appointment isn't for six
10 weeks there's a pretty good likelihood that
11 they're never going to show up to that
12 appointment, so having something there to
13 bridge that time.

14 Integration with primary care, we know
15 that people with mental illness, substance use
16 disorders, have a much higher mortality rate
17 then, than others. Their medications have,
18 have pretty substantial side effects. They
19 tend to smoke more, so their life expectancy is
20 on average twenty years less. So, it's really
21 important that we integrate the primary care
22 with the behavioral health care.

23 And again, that accurate assessment and
24 service linkage, you know, we watch shows, and
25 go, well he needs therapy, he needs this, and,

1 and we kind of come up with these terms that we
2 think will fix everybody, but that's not true.
3 Some kids do not do well in therapy. As a
4 matter of fact, therapy is the exact wrong
5 thing for them. So, making sure that we really
6 look at every individual as an individual and
7 fit the treatment to meet their needs, and that
8 is challenging when you work within limited
9 resources.

10 Again, the right service at the right
11 amount at the right time, engaging folks and
12 keeping them in care, because what we do know
13 is when we do have kids that stay, and we do
14 have adults that stay within our system of
15 care, we have good outcomes. But one of our
16 issues is that we lose a lot of people, where
17 they just quit treatment, or they do their
18 first session and they never come back.

19 Coordinating that care, again having that
20 one single point of accountability that knows
21 what everybody else is doing and can bring
22 those people to the table. And again, lots of
23 opportunities for improvement in the transition
24 from the child system to the adult system.

25 In terms of SB7026, what it did for the

1 Department of Children and Families, it
2 codified the CAT teams, those community action
3 teams. It appropriated an additional \$9.8
4 million so that we could establish thirteen
5 more teams, which brings us to a total of
6 forty. Also appropriated \$18.3 million for
7 additional mobile crisis teams. And mobile
8 crisis teams are available twenty- four/seven.
9 They are pretty much on demand crisis
10 interventions that can either assist in
11 facilitating and involuntary examination, or if
12 that's not what that person necessarily needs
13 helps, a crisis team can follow a person for a
14 little while to make sure that they're linked
15 to the, to the right services.

16 Executive Order 1881 asked the Department
17 of Children and Families to convene meetings
18 with law enforcement, managing entities, school
19 systems, juvenile justice, and service
20 providers to improve communication, and to
21 foster collaboration, to also look at blended
22 funding models. Again, when you have silos you
23 may be funding the same thing somebody else is
24 funding and you don't even know it. And then
25 you, you know, people say, well, we're getting

1 any people, there must not be a need, well that
2 need might, need might be there, and you can be
3 using these resources for something completely
4 different. So, it's really important that
5 people get to the table and talk to one another
6 and coordinate.

7 It also allows the Department to provide
8 criminal justice mental health and substance
9 abuse grants to law enforcement agencies and
10 sheriff's offices, and mandates that all the
11 managing entities have law enforcement
12 representation on their boards.

13 At this point the first Executive Steering
14 Committee convened already, and basically the
15 regional offices, the Department's regional
16 offices are holding their circuit meetings,
17 pretty much as we speak. Most of the regions
18 already had their initial round of meetings.
19 Broward's first meeting is actually on Monday.
20 So, the expectation is, is that the circuits
21 will put together recommendations that we will
22 put into a report in terms of improving,
23 meeting the behavioral health needs of the
24 community while we're meeting the public safety
25 needs of the community. And those

1 recommendations are due to the Governor on
2 January 1st of 2019.

3 And that's it. So, I will now open it up
4 for questions.

5 CHAIR: Questions, Chief.

6 CHIEF LYSTAD: I just have a question as
7 it relates to the silos and the informations.
8 So, if I have a child that maybe comes into law
9 enforcement contact and gets baker Acted in
10 Fort Lauderdale, the child lives in Hollywood.
11 And so, the Fort Lauderdale Baker Acts him. In
12 Hollywood he's being seen by his primary care
13 for a mental illness. And he goes to school
14 in, let's make it Miramar, and the school
15 psychologist there is also seeing issues. Do
16 all of them see each other's information, or
17 no?

18 MS. GAZIOCH: No, not necessarily.

19 CHIEF LYSTAD: And is that a HIPAA issue?

20 MS. GAZIOCH: It is HIPAA. It is a HIPAA
21 issue. But I will tell you this, you know, one
22 of the things that I think, and this is my
23 personal opinion, one of the things that we can
24 definitely do better with is making sure when
25 any kids or adults come into our system get

1 releases of information. That is your -- it's
2 the easiest way, I mean that is really what
3 HIPAA is about, that person is giving you
4 permission to share that information. I spent
5 sixteen years in direct care, and I can tell
6 you the only blank forms that I carry to every
7 home visit, that I had in every folder, were
8 releases of information, blank ones.

9 And, you know, when you, when you do that,
10 that's part of a really good assessment
11 process. So, when you first see that child --
12 so if that child comes into the CSU, right,
13 that CSU best practice would dictate that they
14 ask the family questions. Now, again it does
15 require that the family, you know, provides
16 that information, but they should be asking are
17 they seeing a therapist somewhere. And then
18 there should be a release of, you know, the
19 next thing should be do you mind if we share
20 information, and you talk about the importance
21 of coordinating those services.

22 In my experience, again that's just my
23 personal experience, I would say in all the
24 years I've practiced I think I had two people
25 refuse to sign releases, and one person take

1 their, you know, release back because they
2 didn't want their mom to know something, they
3 got mad at her. But for the most part really
4 that's a practice that we need to talk about
5 more, because if you have a signed release
6 HIPAA no longer is an issue.

7 CHIEF LYSTAD: Okay, but even with a
8 signed release there still would be no central
9 clearing house.

10 MS. GAZIOCH: No, there's no central
11 clearing house. It would require those two
12 providers to speak to one another. One would
13 have to reach out and, and yes, there's no on
14 central place where there's records or anything
15 like that. No, it would require communication.

16 CHIEF LYSTAD: All right, thank you.

17 CHAIR: Commissioner Petty.

18 MR. PETTY: Thank you, Mr. Chair. My
19 question, I think there's just one, it may be a
20 two part, we'll see, but it goes to this
21 transition from adolescence to adult care.
22 Does DCF -- the first part of my question I
23 guess then is does DCF have a set of
24 recommendations that you could share with the
25 commission about best practices, or things that

1 need to change, or regulations that need to be
2 modified, or laws that could be created that
3 would improve this transition period?

4 MS. GAZIOCH: Sure. I don't have anything
5 readily available, but we can certainly work on
6 that and, and get that to you.

7 MR. PETTY: Mr. Chair, is that something
8 we could entertain? Okay. I guess the -- the
9 second part of the question would be are there,
10 outside of DCF's recommendations are there
11 industry, state, national best practices that,
12 that you're aware of that we are not doing
13 currently in Florida that we could or should be
14 doing specifically around this transition?

15 MS. GAZIOCH: There are -- there are some
16 best practices around independent living
17 programs. SAMHSA currently has a grant, and
18 actually Florida operates one Hillsborough
19 County that addresses specifically the needs of
20 transitional youth. It's called the Healthy
21 Transitions Grant. That particular area has
22 seen very good outcomes. They're using a lot
23 of social media, texting type of interventions,
24 and peer interventions.

25 I didn't talk much about peer services,

1 but peer supports is something, it's basically
2 a person who has lived experience, they're in
3 recovery, and then they go through training and
4 certification to become certified peer recover
5 specialists, and, and we're really hoping to
6 increase the utilization of those in our
7 systems of care, because in this program, the
8 Healthy Transitions Program, for example, they
9 have youth peers, and they do a great job of
10 engaging kids that have literally been living
11 on the streets that have either run away from
12 home or left the child welfare system at
13 eighteen not wanting to have any contact with
14 adults or, you know, basically like I'm done
15 with everything, I'm leaving.

16 And they've been very successful more
17 through media and, and peer services, not
18 necessarily formalized therapy, but to engage
19 those youth, provide them with care
20 coordination, and really work with them on
21 getting jobs, finding stable housing, and, and
22 those type of things. So, yes, I can
23 definitely get you some information on those
24 practices.

25 MR. PETTY: I guess then my, my request,

1 Mr. Chair, would be to get a set of
2 recommendations from DCF, and including sort of
3 industry best practices around this transition
4 period from adolescents to adult, adulthood,
5 and what we should do there. I have one more
6 question, if that's okay.

7 CHAIR: Yes, absolutely.

8 MR. PETTY: When -- when a child enters
9 the, the system of care, and the family is less
10 than cooperative, or doesn't want to cooperate,
11 or refuses service, or is an impediment to
12 care, what, what can be done, what's the
13 procedure, what happens?

14 MS. GAZIOCH: There's not a formal
15 procedure. You know, if they're -- like it
16 depends to what level. So, for example, if a
17 kid was prescribed medication and they're
18 refusing to give it you may make a call to the
19 abuse hotline for, for medical neglect, but
20 that's pretty far- fetched. Again, I think --
21 I think providers, and there are some that do
22 this really, really well, it's about not giving
23 up.

24 Figuring out, you know, continue to work
25 with that family, you really have to have kind

1 of a never give up attitude, and you really
2 have to meet with those parents and figure out
3 what it is that you can do for that family that
4 will again engage them, you know. And I think
5 there ways to do that. There are strategies to
6 do that. It's a lot of times not maybe
7 starting with what you can there for and
8 helping them resolve whatever it is that
9 they're going through.

10 Again, families have multiple needs, so if
11 you're coming in and saying, hey, you know,
12 we're here to do family therapy, and that
13 parent may have a mental health issue of their
14 own, that parents might have serious financial
15 issues, that person might be going through
16 major marital issues. Again, looking at why is
17 it that this person doesn't want me here, and
18 figuring out how to address that.

19 MR. PETTY: So, I thought I had one
20 question, I actually have more. In this case
21 we've heard that, and again we're still hearing
22 more testimony, but that there were
23 recommendations against Cruz having access to
24 weapons, and it, and it sounds like, at least
25 from what we know so far, right, that, that

1 Cruz's mother allowed access, or sort of
2 against the recommendation of mental health
3 professionals.

4 What is the best practice or procedure for
5 a mental health professional that becomes aware
6 of either the patient or a family member
7 contraindicating what, what the recommended
8 treatment should be, or the recommended plan,
9 or program, or whatever? And I'm trying to be
10 very specific because this is a, this is an
11 issue obviously of life and death, potentially
12 imminent harm to that person themselves or to
13 other people, in the case of weapons and things
14 like that, so what should happen?

15 MS. GAZIOCH: Well, if there is imminent
16 harm, so if, and again you do have to follow
17 the statute because of the issues of civil
18 liberties. But if there is imminent harm the
19 Baker Act would be the avenue to use. So, if
20 that person -- but again, you know, you have to
21 meet that standards that's in the statute. So,
22 for example if, if there's a fight in the home
23 and a child threatens their parents, you know,
24 the mobile crisis team goes out. At that point
25 they're able to deescalate the crisis, and at

1 this point the child says, no, no, no, no, I'm
2 not going to hurt them, I was just angry, he no
3 longer meets that criteria.

4 So, you know, at that point however there
5 should be linkages to services but be perfectly
6 honest I am not aware of any actual procedure
7 that a provider, or any kind of anything that
8 the provider can do legally to force a parent
9 into services.

10 MR. PETTY: So, the crisis team comes out,
11 there's an evaluation made. Is law enforcement
12 part of that crisis team?

13 MS. GAZIOCH: Different models --
14 different areas have different models. Some
15 crisis teams go out by themselves. Some crisis
16 teams have partnerships with law enforcement
17 where they say, you know, they'll go out by
18 themselves sometimes, and other times depending
19 on how volatile the situation is they may ask
20 law enforcement to accompany them for safety
21 reasons, but there's not one set rule around
22 that.

23 MR. PETTY: But law enforcement is the
24 only one, I think you testified that law
25 enforcement is the only one that can make an

1 independent recommendation based on witness
2 statements, and things like that. So, if law
3 enforcement is not there there's really not
4 much the mental health professional or crisis
5 team can do?

6 MS. GAZIOCH: It's a clinical decision, so
7 if there's a licensed practitioner on the
8 crisis team, you know, they, if they're
9 observing the person is still agitated, and
10 they might be saying one thing, but their
11 clinical opinion is this person is still a
12 danger, they, they still can. But they have to
13 see that. They have to see the actual
14 behaviors, they have to witness it.

15 MR. PETTY: But -- but who do they go then
16 if they believe there's imminent harm?

17 MS. GAZIOCH: They could initiate
18 involuntary examination, and then they would
19 call law enforcement to do the transport, to --

20 MR. PETTY: And in the case of -- the case
21 of the child if the family refuses, can they
22 refuse?

23 MS. GAZIOCH: Baker Act, no.

24 MR. PETTY: Okay. All right.

25 MS. LARKIN SKINNER: Mr. Chairman, may I

1 answer from a provider point of view what my
2 center's policy is?

3 CHAIR: Yes, go ahead.

4 MS. LARKIN SKINNER: So, I've Baker Acted
5 a number of people involuntarily in my career,
6 and in situations where maybe I didn't do a
7 Baker Act, or I did do a Baker Act and then
8 somebody ended up in my hospital, and one of
9 the things that they were talking about is that
10 they were going to harm someone else, in the
11 past we would notify law enforcement, and if we
12 knew they had guns, or if we heard they did
13 from family, or from them, we would notify law
14 enforcement.

15 But my understanding before the law, the
16 recent law change, law enforcement's hands were
17 tied unless the person voluntarily surrendered
18 those weapons. Not that the law has changed
19 our procedure would be the same, but law
20 enforcement has been given the power to remove
21 those weapons.

22 CHAIR: Senator Book, go ahead.

23 SEN. BOOK: Thank you very much, Mr.
24 Chair. I have a question, because you brought
25 up something interesting about when does a

1 parent, when can a parents' issue, how, how do
2 we trigger the next level. And I think in
3 Commissioner Petty's example about if you know
4 there's weapons, maybe they're not an imminent
5 risk, would you suggest, perhaps if you didn't
6 have certain policies or procedures in place, a
7 call to the abuse hotline, because that would
8 trigger an investigation from the Department.

9 MS. GAZIOCH: I'm not sure that I would
10 recommend, I think that the policy that was
11 talked about here now, that there is, that
12 police have the authority to remove weapons, if
13 that's the case I think our providers, if
14 parents are not willing to remove weapons, I
15 think if they think even, even if there's not
16 an imminent harm right now, and they don't meet
17 Baker Act criteria, I think it would be good
18 practice for that provider to go ahead and call
19 law enforcement to verbalize their concerns
20 about weapons in the home, to see if those can
21 be removed based on the protective --

22 SEN. BOOK: In this case --

23 MS. GAZIOCH: -- the new -- the new
24 language.

25 SEN. BOOK: In this case though I think

1 that one of the things, this issue was this
2 individual wanted to pursue weapons and the
3 parent did not, they were not stopping that
4 action. So, I think they're not necessarily
5 there, but facilitating, or enabling in my, in
6 my humble opinion constitutes neglect, abuse
7 really, because, you know, you're allowing that
8 individual to have access to dangerous weapons.
9 So, that -- that was one of the one issues.

10 I have a question about the mobile crisis
11 unit. I've been out with the mobile crisis
12 unit here with Henderson to different school
13 settings, and first for that mobile crisis
14 stabilization unit individual to speak to a
15 child who has expressed, in one of the cases
16 that I witnessed, suicidal ideations, that was
17 alerted, you know, the counselor from other
18 students, that counselor needed to get
19 permission from a parent.

20 If a parent, if that parent said I don't
21 want you talking to my child, boom, done,
22 correct or incorrect?

23 MS. GAZIOCH: You do have to have parental
24 consent, yes.

25 SEN. BOOK: So, if that parent blocked

1 access, and that they would be sent away, and
2 that's kind of that --

3 MS. GAZIOCH: Actually, in a crisis
4 situation, a child can consent in a, in a
5 crisis situation. And I don't have the exact
6 language with me today in terms of when and
7 when not a child can consent. I don't know if
8 you can help me out, but I can definitely get
9 that to you. But children actually do have the
10 right to seek crisis counseling without their
11 parental consent.

12 SEN. BOOK: For -- and then if you could
13 do that, but also, and perhaps, Commissioner,
14 you can help from a provider's perspective, to
15 what length of time, because I also know that
16 children can go to a school counselor, for
17 example, one or two times I believe it is,
18 maybe up to three, but then they need parental
19 consent.

20 MS. LARKIN SKINNER: So, it's been a while
21 since I've looked at the specific laws, and
22 there's some confusion in it, because if a
23 child wants treatment for substance use
24 disorders they can get it no matter what age
25 they are without parental consent. On the

1 mental health side however, which is kind of
2 strange, they do, they can ask for it in a
3 crisis, so then if it's no longer a crisis it
4 can't really continue without parental consent.
5 I mean that -- the last time I personally
6 looked at it that's what it said.

7 SEN. BOOK: Thank you.

8 CHAIR: Just to clarify something there
9 just -- is in this situation when Cruz got the
10 firearm, and you said that you would think that
11 it would be neglect, I just want to clarify
12 something, that at that point, is that was
13 already eighteen so it wouldn't be, it wouldn't
14 be child neglect because he was eighteen, and
15 what is mother facilitated was his obtaining a
16 state ID card so that he could then go purchase
17 the firearm, so it wouldn't be.

18 Prior to him being eighteen, we'll hear a
19 little bit more about this, prior to him being
20 eighteen what was also recommended against was
21 he wanted a pellet gun because he couldn't have
22 a firearm, and she got him the pellet gun. But
23 as far as the firearm goes it was after
24 eighteen, and he went on his own, but what she
25 got was the state ID card, so he could do it.

1 Just to make sure we're, we're clear.

2 Secretary Senior, you had a question?

3 SEC. SENIOR: I just wanted to -- and
4 thank you very much for your presentation.
5 It's really important that people understand,
6 and going to Page 5 of the presentation, that
7 this system is really for people that are
8 uninsured or under insured, and it's important
9 that people understand what that means, and
10 why. And I'll tell you, our agency runs the
11 Medicaid program, and we serve in any given
12 month more than two million children, and we
13 cover substance abuse and mental health
14 services for those children, and so they do
15 have health care coverage.

16 Un-insurance for children is, the rate is
17 fairly low around the country. It's a fairly
18 low un-insurance rate in the state of Florida
19 as well, and so the kids that are ending up in
20 this program, we're going to learn about
21 Nicholas Cruz obviously, he was in a program
22 that was here to fill in a gap in the system to
23 make sure he did not fall through the cracks.

24 It is possible if someone had private
25 insurance, or if they had a Medicare health,

1 Medicaid health plan, that, that the scenario
2 that the police chief gave would, the providers
3 would be able to exchange electronic medical
4 records with one another, and in fact the
5 health plan might know instantaneously, the
6 hospital would ping a system, and they would
7 know that an enrollee had been sent to the
8 hospital, and they can communicate with each
9 other.

10 I think we need to -- in this particular
11 system we do need to think about the handoffs,
12 because people could be eligible for Medicaid
13 one day and not eligible for Medicaid the next
14 day. They are going to, in our program,
15 Medicaid was created in the 1960's so you
16 become an adult at twenty-one, and you can lose
17 all of these services at twenty-one. And it's
18 not just a matter of a hand off, you go off
19 what's referred to as a cliff, right? You had
20 -- our service package for kids is we cover
21 everything that's medically necessary in
22 unlimited amount, duration, and scope.

23 You know, eligibility for an adult, there
24 are limited ways to be eligible in the, in the
25 first place, as an adult, but even if you had

1 adult eligibility our service, our service
2 package is very defined, in terms of you get X
3 number of in-patient hospital days per year,
4 you get this amount of physician visits per
5 month, you get this amount, I mean it's a
6 prescribed thing, and the, managing entities
7 then can offer services --

8 MS. GAZIOCH: Beyond that.

9 SEC. SENIOR: Beyond that, because you are
10 underinsured at that point. So, thinking about
11 how these handoffs happen is, is kind of
12 imperative, but we are, we are actually talking
13 about kind of a different, a strange and unique
14 situation for a child in this instance with
15 Nicholas Cruz. It's not that common that you'd
16 have an uninsured, or underinsured child that
17 is above the Medicaid eligibility thresholds
18 but doesn't have any other insurance going
19 through this system.

20 CHAIR: Sheriff Judd.

21 SHER. JUDD: If a child seeks mental
22 health counseling, or the parents send them for
23 mental health counseling, can the mental health
24 counselor communicate back with the parent
25 about the status, and how counseling is going,

1 and how they are responding to it, and so
2 forth?

3 MS. GAZIOCH: So, in terms of HIPAA the
4 parent is the guardian of that child. There
5 are things that are confidential. They may not
6 go -- a therapist doesn't have to go into every
7 detail of a session, but they certainly can
8 provide a parent with updates, in terms of it's
9 going well, he's participating, and so forth,
10 but the actual therapy notes have a protection.

11 SHER. JUDD: Okay, see, that's one issue.
12 So, you refer your child for mental health
13 counseling and then the therapist cannot
14 legally share with you the details of the
15 counseling, so if the, if the child is not
16 cooperating with the, with the counseling, you
17 can say the child is not cooperating?

18 MS. GAZIOCH: Yes.

19 SHER. JUDD: If the child says, you know,
20 I have these ideations about stabbing mom in
21 the middle of the night, I don't really want to
22 carry it out, but I think about it, can you
23 share that information?

24 MS. GAZIOCH: If the -- if the clinician
25 feels that that's a true threat then yes.

1 SHER. JUDD: But if they in their
2 subjective opinion think it's not a true thing
3 then they can't.

4 MS. GAZIOCH: Right.

5 SHER. JUDD: So, you have an environment
6 currently where there's the amount of
7 information that can be shared with a parent is
8 restricted by HIPAA, and is determined with a
9 subjective, based on their experience and, you
10 know, their training, so they get, they have to
11 make a subjective statement about what they can
12 say and how much they can say, but they can't
13 talk about the details of what's occurring.

14 How much of that can be shared with law
15 enforcement, and, and I say law enforcement,
16 that always raises everybody's flags in the
17 mental health world, but you're having this
18 ongoing dialogue with this child that you're
19 helping, but this child continues to talk
20 about, well, you know, I think about killing
21 people, I don't think about killing people, I'm
22 angry that my mom does this, I'm angry that my
23 dad does this, I'm angry because, and so we've
24 got this, this environment here, and maybe, and
25 this particular scenario we're fortunate enough

1 that somebody is there. How much of that can
2 be shared?

3 MS. GAZIOCH: Well, if there is a threat
4 that can be shared. And again it's, you're
5 right, there is clinical discretion. I mean
6 the entire, you know, behavioral health field,
7 there's a lot of research, there's -- but still
8 clinicians have to make clinical decisions all
9 the time, that is what they're trained to do.

10 In terms of, you know, and one of the
11 things that they are trained to do is they
12 should as a clinician be able to determine
13 what, what rises to the level of, of a true
14 threat that needs to be shared. But again, a
15 lot of these things can be addressed in the
16 beginning. I mean there are reasons that we
17 have that the therapeutic sessions are
18 confidential, right, because a lot of times,
19 you know, we have abusive parents, a lot of
20 times things like sexual abuse, physical abuse,
21 are disclosed in therapy sessions, and there's
22 an argument to be made that much of that would
23 not be disclosed if a child thought that
24 everything they said in therapy would
25 definitely be said to their parents.

1 So, it works both ways, so again you,
2 you're constantly striking that balance. You
3 want that child to be honest with you, and up
4 front with you, but one of the things that
5 every clinician, every, every person in the
6 behavioral health field should be doing at time
7 of intake, be very clear about what is
8 confidential, what is not confidential. Abuse,
9 neglect is actually not confidential, but it
10 doesn't necessarily be told to the parent, it
11 has to be, you know reported to the abuse
12 hotline.

13 And in that, when a clinician works with a
14 child, and builds that therapeutic rapport, one
15 of the things that they're usually working on
16 is building trust between that child and the
17 parent if it's not an abusive situation, and,
18 and you talk to that child, and you can get a
19 scent from that child to, to tell the parent
20 about what's going on, and if there are truly
21 those issues with a family then a clinician
22 also have the duty to make a good clinical
23 decision to say we really need to have family
24 therapy here so that both the child and the,
25 the parent are in the session together.

1 So, again, therapy comes in many different
2 forms, shapes, sizes. It's not always just a
3 therapist meeting with a child. Really, you
4 know, when we do look at best practices for
5 family, you know, which is one of the reasons
6 our CAT teams are successful, is because it's
7 in the family approach. Really individual
8 therapy, especially when there are a lot of
9 those family issues, may not be the right
10 service for that child. You, you know, you
11 really should be engaging in family therapy.

12 SHER. JUDD: Here's what we're involved in
13 on the ground, from our perspective. The child
14 tells us, and we're taking, we're saying a
15 child, but it can be an adult. We get there
16 and the child, and the child or the adult looks
17 the officer in the eye and goes, you know, I
18 feel like killing myself, or, you know, I'm
19 going to shoot my neighbor, you know, if he
20 comes back outside. And we made some of those
21 value judgments in the past, but as of this
22 horrible event in Broward County we take
23 everybody at face value on their words, and we
24 don't let them change their mind.

25 So, we put them into the system, whereby

1 now the information is not shared backwards, it
2 may, whether it's a child -- obviously an adult
3 is a different circumstance, but it's not
4 shared with a parent, and we're accepting for
5 the purpose of this argument the parents are
6 rational reasonable people, and they're
7 concerned, and what's wrong with my child, and
8 then -- and we had an event on one of these
9 RPOs recently where the guy shows up to the
10 judge and says, oh, I was just kidding, I
11 didn't mean I was going to shoot myself, and
12 the judge gave him his guns back.

13 While we're accepting people who are not
14 rational at face value, and I don't know if
15 there's an alternative to that in the mental
16 health world, and many times in the court
17 world, and we're on, in the ground, on the
18 ground trying to make sure the next massacre at
19 a school doesn't occur, and somebody say, well,
20 daggummit, you know, you Baker Acted him
21 because they had these ideations, and mental
22 health goes, well, we can't talk about it, and
23 the guy shows up with a gun and starts
24 shooting.

25 I think that's the frustration that we're

1 all at right now. And one of the -- and we'll
2 get into it later on with Cruz, but these kinds
3 of events apparently occur over and over, and
4 over, and over, and over, and the copes are
5 going well, and the neighbors are going well,
6 and the teachers are going well we could have
7 predicted that because we've been dealing with
8 this person and that conduct.

9 So, I guess I said all that for mental
10 therapy for me.

11 MS. GAZIOCH: I'm glad you could get that
12 off your chest.

13 SHER. JUDD: How the -- how do we -- how
14 do we create a process, or a system where we
15 can get all of this, all of this individual
16 data put together, and break down these silos,
17 and make sure they get services, and that we
18 are able to follow their ebbs and flows in the
19 process?

20 MS. GAZIOCH: Yes, I mean the
21 communication pieces, and the silos, like I
22 said, I mean those are issues. Again, if you
23 would ask my preference it would be I, I would
24 love to see that the first contact for, for
25 behavioral health care is not a Baker Act.

1 Unfortunately, currently that is one of our
2 main ways to get into the system, but again I
3 think if we put more emphasis on our community
4 system, because that's where people get well.
5 People don't get well, people get stabilized on
6 a crisis unit, and they are absolutely, I mean
7 they must be there, you must have that place to
8 take somebody for safety, but I think the more
9 we can do early on working with families and
10 children, the quicker that we can intervene, I
11 would hope that we wouldn't have that many
12 contacts with, with Baker Act.

13 SHER. JUDD: Well, that's part of it, but
14 how, how do we share that data, or, or track
15 that data so that, you know, we truly don't
16 want to know the intimacies that need to be
17 confidential, but we need some kind of a
18 barometer that this person is, is meandering
19 through this system over and over, or is not
20 responding, or continues, not to be a threat, I
21 mean they haven't reached that, wherever that
22 line is in the subjective world, but what's
23 your idea about a system or a process so that
24 we can monitor that individual without it being
25 any kind of public record, or we can be part

1 of, part of the super confidential system, but
2 those of us trying to prevent these shootings
3 all know about these people?

4 MS. GAZIOCH: It's an interesting concept.
5 Again, I think as Commissioner Senior pointed
6 out, you know, there's, there's a data system
7 around Medicaid that captures people who have
8 Medicaid. Then that person loses Medicaid and
9 now they're in our system. And at this point
10 I, I don't have a good answer for you in terms
11 of, of that. But you're absolutely right, the
12 best predictor of future behavior is past
13 behavior, so this constant, well, this one
14 knew, and this one knew, you know, I think we
15 have to, even if it's not data points, because
16 we're not there yet, there yet in terms of the
17 technology, but at least starting with better
18 coordination between all the people that touch
19 that person, and that would include the school,
20 the provider, so that again whether that's a
21 care coordinator or a case manager, but where
22 all those pieces of information land in the
23 same place until we have better technology to
24 do that.

25 SHER. JUDD: And -- and that's the whole

1 -- to me that's the cornerstone of what we're
2 trying to do here, because after the fact
3 everybody knew he was going to do it sometime,
4 but none of the dots ever got connected in
5 advance, and truly the possibility is there to
6 connect the dots, but we got to have some
7 systems' changes, and some paradigm shifts I
8 think.

9 CHAIR: Sheriff Ashley, and then Secretary
10 Carroll.

11 SHER. ASHLEY: Thank you. Great
12 presentation. I, Sheriff, Commission, I think
13 we already have that available, and the
14 subjectivity is what's killing us, for lack of
15 a better word. Florida Statute 456.059 for
16 psychiatrists, 491.47 for psychologists,
17 491.147 for social workers, all protects those
18 individuals from civil liability for divulging
19 privileged communication in suicidal and
20 homicidal patients that, that express a threat,
21 that I want to kill my neighbor, I want to kill
22 my mom, I want to kill. They're all protected
23 from divulging the information. They can call
24 us and tell us that.

25 The subjectivity comes in, are they

1 serious or not when they make these threats to
2 us, when they make these statements to us as
3 service providers, and there is no mandate that
4 says you have to call law enforcement and say
5 that this subject is suicidal, or homicidal,
6 and is threatening to kill this person or that
7 person. And I think we as a commission could
8 certainly make that recommendation that that
9 should be a mandatory report if you're suicidal
10 or homicidal, that law enforcement should know
11 that in order -- you know, we put intel flags
12 on people all the time when we respond to
13 residences that they've got this issue, from
14 universal precautions to violence, to the like,
15 so I don't know why we wouldn't do that when an
16 individual actually expresses that threat, and
17 take them at their word. So, just that point.

18 CHAIR: Secretary Carroll.

19 SEC. CARROLL: Just from a little bit
20 different standpoint, the slide that Ute
21 originally showed around the stigma, half of
22 the issue we have, or a big challenge we have
23 in getting folks to engage in mental health
24 treatment, particularly with parents of
25 children who may have a mental illness, is

1 they're reluctant to have their child
2 stigmatized, so they, rather than seek
3 treatment they hide it. And so, we want to
4 find a way to get these folks to bring kids
5 voluntarily to get treatment, because we
6 believe the earlier the better.

7 Most practices would tell you that if you
8 have a mentally ill child you better have some
9 family therapy attached to that counseling for
10 the child, because the parent needs to develop
11 the skills to parent a child with a mental
12 illness or behavioral disorders. What we see a
13 lot with kids early on, before they're
14 diagnosed with a serious mental illness, is you
15 have behavioral health issues, conduct
16 disorder, that type of stuff that you see start
17 displaying itself.

18 The only way that we can address that, we
19 can bring a kid into counseling, but you have
20 to have the parent there at the table because
21 they have to have the skill to begin parenting
22 in a way that sets consequences, and helps that
23 child, kind of like behavioral analyst approach
24 to, to raising a child, so -- and I think we
25 try and do that more and more. We don't have

1 enough services on the street to do that quite
2 frankly.

3 We have -- we talked about these CAT
4 teams. Five years ago, we had none.
5 Commissioner was the first to have one. We now
6 have forty-two. I would tell you we don't have
7 enough, because they provide, the beauty of
8 those teams is they not only provide individual
9 counseling and therapy to the child, they
10 provide intensive parental support to folks in
11 that home to understand what they're dealing
12 with, and what they should be doing from a
13 coping mechanism, and when an alarm should go
14 off to them. So, I think a lot of that has
15 helped.

16 I do agree we have to find a better way to
17 -- in terms of the data piece, sharing if
18 information with parents to me is a no brainer,
19 the parent should get this. Now I don't that
20 they should get everything that somebody says
21 in a therapeutic session, because they might as
22 well be there if that's the case, and if
23 they're going to be there you're not going to
24 get everything from the child, but they do need
25 to get what they need to get to keep their

1 child safe and progressing.

2 From a data perspective, we worked with
3 AHCA because AHCA has a wealth of information
4 on kids who receive, and adults quite frankly,
5 receive behavioral health services through
6 Medicaid. We have the community mental health
7 system, which is what we call the system of
8 last resort. You have to exhaust all other
9 resources before you come into our system. We
10 could never see into the Medicaid system. A
11 lot of folks go between our system and
12 Medicaid. Not all. I think if you added up
13 the folks that go through our system and the
14 folks that go through the Medicaid system it
15 accounts for about two thirds of the folk who
16 receive mental health services in the state.

17 But we do a much better job now of
18 providing that information to the managed
19 entities who manage this on the ground in every
20 community, where at least now for the first
21 time, and this was just in the past year, where
22 they can see from a, from a data perspective
23 where the folks they're serving are hitting,
24 you know, because it used to be we successful
25 with this person or did this person just go

1 into jail for six months and the reason they
2 haven't been receiving services is because
3 they've been incarcerated. We never knew.

4 Now we tend to pick more of that because
5 of the data sharing, but we still don't have
6 private pay insurance on there. I think the
7 biggest thing if you're talking about the Baker
8 Act specifically, and Ute referred to this, and
9 I think this is one of Sheriff Gualtieri's pet
10 peeves, is when somebody comes out of the Baker
11 Act if they're eighteen, any age, we can't
12 force them to engage in services. So, if they
13 absolutely are adamant that they don't want
14 services we can't force the services on them,
15 however we can do a lot better job at
16 aggressively and proactively engaging them and
17 helping them understand it's in their best
18 interest to engage in services rather than just
19 release them with no one hand off, and no
20 connection to a service.

21 And that is something that we have to
22 work, when Ute was talking about coordination
23 of care, that's a gap that exists in every
24 community. It's something that we have
25 prioritized within the Department. It's a gap

1 that has to be closed, and each one of the
2 managed entities, it's something we are
3 actually developing measures around to see if
4 they close it. And quite frankly it was onus
5 behind the executive order that the Governor
6 issued, was to try and find out for those folks
7 that are either released from jail or released
8 from a crisis unit who are dealing with these
9 issues, who is doing that proactive follow up,
10 and trying to engage these folks in services.

11 If they adamantly refuse there's not
12 anything we can do, it's their right, but most
13 wouldn't adamantly refuse the services. Most
14 refuse the services because they go out, they
15 go about their life, they don't think they need
16 the service, they don't have the wherewithal to
17 get to the services. Some of them don't have
18 stabilized housing. There's a whole complex
19 reason why they don't, but we've got to get
20 better at that. And it's a huge hole in our
21 system, because it creates a revolving door
22 with the law enforcement, and also within our
23 crisis unit. So, to me there's different issues
24 here.

25 And with respect to Cruz, and this is an

1 important distinction, was even when the folks
2 locally who went out to do the Baker Act
3 assessment, he had already turned eighteen, and
4 so he had the right at that point to refuse to
5 go further. They at that point assessed him as
6 not meeting criteria, but he was eighteen, he
7 had the right engage in the adult protective
8 investigation that took place or disengage. He
9 had the right to engage in services or
10 disengage.

11 And unless he was doing something criminal
12 at that point there wasn't a lot that the
13 social workers could do because he turned
14 eighteen. It changes when -- when there's a
15 child and they're refusing treatment if we find
16 that that child absolutely has to be in
17 treatment you can call, and abuse investigation
18 and we'll look at it, and if in fact that child
19 has a serious mental health diagnosis, and the
20 fact that you're not seeking services is
21 putting that child or others at risk, that's
22 absolutely something we can then intervene in.

23 It's not different than if your child had
24 cancer, they just had an organ removed because
25 of cancer and all of the doctors say you have

1 to have ongoing radiation, or chemotherapy, and
2 the parent says, well, no, and the docs are
3 telling us there's a ninety percent likelihood
4 that the cancer will return, is that abuse and
5 neglect. Well, it depends, if you go out and
6 the parent say we understand that but we're
7 using alternative medicine, and we think this
8 gives our child as good a chance as the chemo,
9 that's one thing. But if you're doing nothing,
10 well that's, probably most folks would say
11 that's kind of negligent and, and reckless to
12 the livelihood of that child, so it would have
13 to be independently looked at.

14 So, for a child we have a little bit of
15 room to intercede when they refuse, although in
16 the end if there's not a diagnosis, and there's
17 not evidence that the parent is abusing and
18 neglecting the child, there's nothing we can do
19 to force them into treatment. But I do think
20 the Sheriff, and I've heard the Sheriff talk
21 about this over and over, for those folks who
22 are released from these, and we talked about
23 it, on Baker Acts you can be released not in
24 eight hours, or ten hours, you can be released
25 in two hours if they deem you not to meet

1 criteria.

2 That does not mean you don't have an
3 issue, and the fact that we release you out
4 onto the street with no one hand off, no
5 services in place, is creating an issue where
6 the next time something more serious may come
7 of it, and so that's the piece I think we need
8 to get our arms around.

9 CHAIR: Secretary Carroll, you're right,
10 and you know you heard me say it a thousand
11 times, it is a pet peeve of mine, and I've been
12 very vocal about it, is, is the greatest void
13 in the system right now is case management
14 navigation, wrap around services, whatever you
15 want to call it, and discharge planning for
16 many of receiving facilities is not existent,
17 and you have people that are going in under the
18 Baker Act, and in some cases they're there for
19 an hour, two hours. Sometimes they might be
20 there for seventy-two, but that's rare in my
21 experience, and most of the time are released,
22 and there's a huge gap.

23 And the reason why there's a huge gap is,
24 without beating a dead horse with it, is, is
25 because these people, if they, for blanket

1 statement, but if they could make it work on
2 their own they would. They can't. They need
3 hand holding, they need services, and you have
4 a much better outcome with intensive services
5 and follow up than you do leaving it to their
6 own volition to try and get help. It doesn't
7 work. And the greatest void in the entire
8 system in this state, and probably other
9 places, is whatever name you want to put on it,
10 is somebody holding their hand and getting them
11 to the best possible place that you can get
12 them, and we don't have that.

13 And, you know, and in this case, like with
14 Cruz as an example, he fell off the grid. And
15 if we get to it this afternoon you'll see as we
16 go through the Henderson records, is there was
17 intensive, intensive contact that he had with
18 Henderson, and then when he turned eighteen and
19 he refused services, and then soon after that
20 he move, he moved to Lantana, and when he was
21 living up in Palm Beach County he's living with
22 somebody else, and then he comes back down here
23 and he's living with the family he lived with,
24 so he, he fell off the grid, he fell off radar.
25 There was nobody that was looking at him, and

1 the intensive services abruptly stopped for a
2 bunch of reasons. One is turning eighteen, and
3 he left Broward County, went to Palm Beach
4 County, he was floating around, and nobody knew
5 where he was staying.

6 So, you know, you end up with, and
7 Commissioner Petty, getting back to what you
8 said a little while ago in this, is that
9 there's a, and Sheriff Judd, there's a gap,
10 there a delta, and that gap and that delta is
11 somewhere between okay and somebody that meets
12 the criteria for a Baker Act. And there's a
13 whole lot of people that fall in this gap, in
14 this delta area. And Ute, like you said is, is
15 that these people, and a lot of it, a lot of it
16 is a determination about whether you get Baker
17 Acted or not. It is subjective, and a lot of
18 it turns on whether you say the right thing or
19 the wrong this, right?

20 MS. GAZIOCH: It is, yes.

21 CHAIR: And if you say the magic words
22 you're going, and if you say something short of
23 the magic words, or you have learned to say
24 things that are short of the magic words, then
25 you're not going to get Baker Acted. Then once

1 you get into the receiving facility -- the
2 definition of stabilization from a crisis
3 stabilization unit standpoint is also
4 subjective, and a clinician's determination
5 that somebody is stable, have met the
6 definition of releases from the CSU after a
7 Baker Act, may be different, very different
8 than mine or yours.

9 We may not want that person on the street,
10 but their job is, is to get them from here, not
11 to here, is to get them from here to here, and
12 then they discharge them, but again they're
13 discharging them with no discharge planning, no
14 follow up services, and the next time that
15 anybody has contact with them is when they get
16 back up to here again.

17 So, and if you disagree with any of that
18 you're welcome to --

19 MS. GAZIOCH: No, and I think that's our
20 practice, I mean they have to do discharge
21 planning, that's part of rules, but if they
22 don't it needs to be reported, and we need to
23 look into that.

24 CHAIR: And the most concerning people are
25 the people that are in this gap, and this is

1 where a whole bunch of them are, is in the gap,
2 so the question comes, is, is that is there
3 something we could recommend, is there
4 something the legislature can structure, is
5 there something there. But you have to balance
6 it against civil rights because you're
7 depriving people of their freedom. Is there
8 something that you can do that's short of the
9 Baker Act but will identify and do something to
10 deal with this conduct that isn't an imminent
11 danger to themselves or others.

12 And that's -- and that's the dilemma.
13 This is a -- this truly is a dilemma situation.
14 And that's where we are -- and -- and here, you
15 know, in Broward, I don't think Broward is any
16 different. Well hear from the managing entity
17 here in a second, but I don't think they're any
18 different as far as the level of case
19 management is concerned.

20 MS. GAZIOCH: Well, actually I think
21 you'll be surprised at some of the things that
22 Broward is implementing.

23 CHAIR: Good.

24 MS. GAZIOCH: And you're absolutely right,
25 I mean we started our care coordination efforts

1 about three years ago when we were looking at
2 data for something completely different and we
3 saw that, you know, out of these seventy
4 thousand people who were Baker Acted only about
5 thirty thousand were receiving case management,
6 and we said how is that possible if you're
7 supposed to, you know, you're supposed to be
8 discharged with a discharge plan. It's
9 supposed to include medical needs, it's
10 supposed to include an appointment for a
11 physician. If you've been placed on
12 medication, you need to consider that.

13 So, those -- the rules are in place, and
14 I, so I think it's a practice issue. I know
15 that in the areas where we've really
16 concentrated on the care coordination efforts,
17 and we started it without funding, and we
18 really challenged our MEs and providers to put
19 it in because we didn't have any extra funding,
20 we've gotten some since then, but for example
21 in Miami they had five people who were
22 literally never, over years and years engaged
23 in services, and were in and out of, I mean
24 talk about a revolving door, they were the five
25 highest utilizers, and it was all crisis

1 stabilizations, and they implemented warm hand
2 offs with really intensive care coordination.
3 In a year in care coordination those people
4 were not re-hospitalized.

5 So, I think, you know, I think there are
6 ways of doing it. I know Centerstone had
7 implemented even before we started our care
8 coordination high utilizer care coordination
9 programs. It is a matter, you know, part of
10 the issue is, is that you, you know, you need
11 to bring that up to scale, and at this point
12 there's not necessarily all the resources there
13 need to be to do that unfortunately, because
14 you can't, you know, when you already have a
15 system that's very, you know, you're already
16 investing in your doctors, and you have to have
17 your CSUs, you can't just take money from that
18 and put it into something else because you'll
19 just create another gap.

20 So, but I -- but I do think the care
21 coordination piece, and the warm hands off
22 certainly have huge promise.

23 MR. SCHACHTER: In Los Angeles they have a
24 program where they have, you know, their top
25 fifty high risk individuals, and they are

1 constantly check up on them. I can't remember
2 the name of it, but even in mass casualty
3 events like in Parkland, I'm sure that they
4 touched all those top fifty individuals, and I
5 think it's, this is part of something that we
6 need to recommend, it needs to be that, you
7 know, constant touching, and making sure, and,
8 you know, even more so. But thank you for your
9 testimony, it's wonderful.

10 I just wanted to follow up on Chief
11 Lystad's remark. You know, he asked you one
12 specific question, and to see if there were
13 these silos and sharing information. I wanted
14 to ask you a more broader question. You have
15 visibility to all these different programs, are
16 you, can you identify for this commission any
17 other silos that are not sharing that you think
18 would be beneficial once we make
19 recommendations?

20 MS. GAZIOCH: Well, again I think all, you
21 know, we talked about different state agencies
22 provide services. At this point none of those
23 data systems are connected, so if a young
24 person was receiving clinical or therapy
25 services through DJJ because the had been

1 arrested, or had contact, and then if they
2 showed up at the community mental health center
3 for something else unless they reported it
4 there is no connection, there's no, no, there's
5 not one data system that has all of this, and
6 that, those -- exactly.

7 MR. SCHACTHER: What else? Perfect. This
8 is exactly what we need to know. What else --
9 and, you know, we --

10 MS. GAZIOCH: Education. Education has
11 their own system. Juvenile Justice has their
12 own system. We have our -- it's all different
13 data systems.

14 MR. SCHACTHER: And when you're putting
15 together Commissioner Petty's, you know, best
16 practices, if you could list those for us that
17 would help us.

18 MS. GAZIOCH: Okay.

19 MR. SCHACHTER: Thank you so much.

20 MS. GAZIOCH: Secretary Carroll, go ahead.

21 SEC. CARROLL: Real quick to add to that
22 too. One of the big holes specifically related
23 to the schools is connecting the community,
24 mental health community directly with the
25 schools, because even as we beef up schools'

1 ability to provide this type of counseling to
2 kids, kids don't live at school, they live at
3 home, and in the community, and anything that's
4 going on in the school has to be continued when
5 they go home, and in the community, and if
6 they're receiving community services it really
7 has, there has to be a stronger link.

8 I'm hoping that the creation of these
9 threat assessment teams, that brings all of
10 those people together, and quite frankly I
11 believe the law allows them to share
12 information openly. I hope that corrects that
13 information sharing at some level with some
14 kids, but I think it's critically important as
15 schools begin to plan how they're going to
16 implement and utilize the additional mental
17 health resources that are being provided to
18 them through the law, they need to be able to
19 connect that to community mental health
20 services, because these families are often
21 involved in multiple different places, and if
22 that link isn't made these silos are going to
23 continue.

24 CHAIR: Without too -- and then Secretary
25 Senior, one second. But one of -- one of the

1 things that I wish we had, and I'm an advocate
2 for, I don't know if we'll ever see it, is
3 actual case management entities, because I
4 believe that there has to be ownership, and
5 somebody has to own these people, and be
6 responsible, and there has to be a top of the
7 funnel, that somebody is ultimately
8 accountable.

9 And you have some entities that engage in
10 case management to some degree, and some that
11 are trying. But as they're bouncing around
12 between school counselors and private
13 therapists, and the whole system back and
14 forth, it is related to these people that are
15 of most concern, and have the most need, there
16 isn't one person who objectively is overseeing
17 them, and it's my characterization, owns, them,
18 and when I say ownership I mean responsibility
19 and accountability for them.

20 And I think that the providers do a great
21 job in providing, but case managing is, case
22 managing is different than providing, and that
23 to make objective decisions it would be best
24 suited by a person in an entity that isn't in
25 the business of providing services, it is in

1 the best position of navigating those services,
2 sending them there, bringing them back, sending
3 them here, bringing them back, to get into the
4 best possible place. Some people, you will
5 only get them to this place, you'll never them
6 all the way, but at least you can get them to
7 the best possible place they can and then
8 continue to monitor them.

9 But until we have more effective, and is
10 this still a true number, is, is that Florida
11 is the third largest state in the country and
12 depend upon whose numbers you use per capita
13 funding we rank around forty ninth or fiftieth.
14 Is that still an accurate number, or is that --

15 SEC. CARROLL: Well, there would be --
16 there would be some debate on what the actual
17 number is, but in general yes.

18 CHAIR: General, generally. So, when we
19 have that, and the investment where we are the
20 third largest state and somewhere around the
21 forty ninth or fiftieth in per capita funding
22 in mental health, that's why there is not
23 enough resources in the case management world,
24 because you've got to provide services, and
25 there's a huge gap, but you can't fix that gap

1 unless there's funding for case management.
2 And it's just simply you have to make choices,
3 and if you're choosing between actually
4 providing services or providing intensive case
5 management -- and that's why you see a lot of
6 local entities that are implementing their own
7 case management programs. And it's happening.
8 It's happening in our county, it's happening
9 other places.

10 Secretary Senior, go ahead.

11 SEC. SENIOR: I just wanted to say and
12 this -- at a state level I think there's a
13 great opportunity. Our agency is procuring
14 right now a new enterprise system that is going
15 to, is intended to create a platform that will
16 allow this type of information sharing across
17 state agencies, whether it be DCF and the
18 Agency for Healthcare Administration, the
19 Department of Juvenile Justice, but any,
20 giving, giving these entities access to our
21 information, and giving them the opportunity to
22 input their information into our system so, so
23 we would have a location, a location.

24 That's going to be I think very important
25 for children. Obviously when you get to the

1 adult realm most, most adults aren't going to
2 be enrolled in Medicaid anywhere in the
3 country, and so you've got all of these private
4 insurance companies, or uninsured folks, and it
5 becomes a little bit more difficult to break
6 down potential silos, and it almost has to
7 happen at the provider level, with the
8 providers being capable of exchanging
9 electronic medical records, and people really
10 owning their own medical history.

11 UNDER SHER. HARPRING: Mr. Chair.

12 CHAIR: Go ahead.

13 UNDER SHER. HARPRING: You know, regarding
14 the follow up and the case management, there's
15 already a template that exists for that for
16 those jurisdictions that have mental health
17 court, veterans' court, as we do in the
18 Nineteenth Circuit, as well as drug court. And
19 I think that the template exists, but as with
20 many of these things the issue comes down to
21 either local legislative bodies, or state
22 legislative bodies, it's the willingness to
23 provide the funding for it, because you have to
24 have the people that are dedicated to do it.

25 But I've seen that in the Nineteenth

1 Circuit where I reside, that, that our
2 personnel, and it a community approach because
3 we have personnel that work for the Sheriff's
4 Office where, where I am, as well as people in
5 the mental health community, that track these
6 individuals. Now of course keep in mind
7 they've some into our purview because we've
8 arrested them, and they meet certain criteria,
9 but they are assigned a case manager, and that
10 case manager assists with, and a lot of times
11 you have these, you know, coexisting issues
12 with substance abuse and mental health, much of
13 the time, and they have a case manager.

14 The case manager ensures for a period of
15 time that once they are released from
16 incarceration that they're getting to their
17 counseling sessions, they're getting their
18 medication, they're getting stabilized in
19 residences, and I think that that template
20 exists. But as with almost everything that
21 we've talked about a lot of that comes down to,
22 you know, comes down to willingness.

23 And I just would like to say one thing
24 about the, the database issue. We've talked
25 about that in a lot of other areas, and this

1 might be a little counterintuitive, but I on
2 some level caution the commission on, on having
3 large databases accessible to a lot of people,
4 or a lot of different entities relative to
5 people's mental health, because we know many
6 times people that are Baker Acted, sometimes
7 they are one and done, and sometimes we're
8 trying to resolve, from the law enforcement
9 side we're trying to resolve something in the
10 field, it meets the criteria and we do that,
11 and then that person doesn't come back.

12 And then of course there is that follow up
13 with a lot of people that we know who they are,
14 we have the flags in our system, we're heading
15 to the residence for a call for service and we
16 kind of already know what, what the result is
17 going to be. But let me cycle back real quick
18 on that, on that same topic, in that we have
19 seen a great reduction in recidivism relative
20 to the people that have come into our
21 particular purview on the law enforcement side,
22 that have gone into either veterans' court,
23 mental health court, or drug court, and I think
24 that that template could potentially be
25 something that should be looked at by those

1 that are going to move forward in this
2 particular area.

3 CHAIR: Commissioner Petty, as we wrap
4 this up.

5 MR. PETTY: Yeah, just a quick comment I
6 think. So, if there are models for case
7 management that we could look at and replicate
8 in this area, I think that's interesting. It
9 goes to a comment that Commissioner Carroll
10 made a moment ago, is, you know, I think you
11 mentioned, you know, school districts start to
12 think about bringing these services in, we may
13 want to make some recommendations about, to
14 your point, on case management, where that
15 should happen. Should that be the
16 responsibility of the school district, or
17 should that happen in the community? I don't
18 know where, but should that happen in some
19 other entity that doesn't, that can ensure that
20 when that student goes home that there's
21 continued follow up and, and proper case
22 management.

23 So, I don't have an answer, but it's
24 something --

25 CHAIR: You know, and maybe -- maybe we

1 could have a, you know, follow up discussion on
2 this and, we were having an informed
3 discussion, but, you know, an enhanced informed
4 discussion after you have an opportunity to see
5 and have it all laid out as to what Cruz did
6 receive, and give you an idea as to the
7 intensity of it. And it may help round out the
8 discussion on this, so why don't we, you know,
9 we'll continue that discussion once you've had
10 an opportunity to see what happened here and
11 compare it to what we've now heard. Yes, go
12 ahead.

13 MS. LARKIN SKINNER: As the, the way the
14 system works right now to identify a high need,
15 we call them high needs, high utilizer, so
16 identifying someone with high needs, typically
17 they are a high utilizers of systems, of the
18 system, and all the services in the system.
19 With regards to what this commission is tasked
20 with in looking at the Parkland massacre, and
21 the perpetrator of that massacre, I haven't
22 heard anything yet that would have tagged him
23 as that, and therefore would have made anyone
24 go, hmm, you know, perhaps he should be in case
25 management.

1 And I'm only saying that because I just
2 haven't heard anything yet. I mean if he
3 wasn't in and out of a crisis stabilization
4 unit I don't know that he ever would have been
5 tagged as somebody that we would then go out,
6 try to engage, and wrap services around.
7 Because there are models for that, even beyond
8 mental health court, drug court, and veterans'
9 court.

10 So, that's something I think that as we
11 listen to his life being built out in front of
12 us, that we consider that, because it may even
13 be that we need a different mechanism for how
14 we tag that, of how we flag those people. Law
15 enforcement has a mechanism, and I know that
16 because after Parkland in our county we had
17 five or six kids in their infinite wisdom
18 talking about how they were going to do
19 something at school, they were going to kill
20 somebody, do this, do that, and two of them
21 happened to be in services with Centerstone, my
22 company, and so I contacted the Sheriff's
23 Office and we talked about what our process
24 would be to, to notify, and one of the things
25 they told me is that they had at least two of

1 like four of the kids on a watch list already.

2 So, I know in law enforcement they had a
3 watch list for these folks that were high risk,
4 not because necessarily of their mental health
5 issues but because of the threats that they
6 were making and their past behaviors. Just
7 food for thought.

8 CHAIR: Okay. All right, why don't we
9 hear from the managing entity? Ute, thank you
10 very much, it was a great presentation.

11 MS. GAZIOCH: Thank you.

12 CHAIR: We appreciate you being here. So,
13 I don't think this next presentation is going
14 to take very long. It will be kind of a
15 follow, segue way into, from where we were into
16 the Broward County mental health system, and
17 the presentation from Silvia Quintana, who is
18 the CEO of Broward Behavioral Health. Welcome,
19 and thank you for being here.

20 MS. QUINTANA: Thank you so much for
21 inviting me and having me. How do I get this
22 going? Okay, so I'm here to present on the
23 managing entity for Broward County, which is
24 Broward Behavioral Health Coalition. We were
25 asked to present on the services that we

1 purchase from our network, and also the gaps
2 that we see in the system, so this is what this
3 presentation is about.

4 So, Broward County was funded this past
5 fiscal year '17/'18 with \$57.8 million. We
6 purchased -- we purchased about \$34.2 million
7 in mental health services, that's fifty nine
8 percent of our budget, \$20.9 million in
9 substance abuse services, and about four-point
10 four three percent. \$2.5 million is our
11 operational oversight. Of the substance abuse
12 and mental health funds \$2.4 million is used
13 for prevention services, to do prevention
14 substance abuse and mental health promotion.

15 The role of the managing entity, and I
16 think Ute presented this before, is to really
17 oversee, is to then provide the administration
18 management support oversight of the DCF funded
19 behavioral health system of care in Broward
20 County. Our mission basically is to be, have a
21 responsive compassionate behavioral health care
22 experience for people in our community, and,
23 and our mission and values are spelled out
24 there.

25 Okay, this is the \$2.4 for prevention that

1 I wanted to point out. We served in fiscal
2 year '16/'17 approximately twenty-seven
3 thousand individuals, adults and children. You
4 see the spread there. The reason why we have
5 such little numbers in youth, this is eighteen
6 and under, is because a lot of them have
7 Medicaid, and so therefore we are only serving
8 either the, either gaps, or kids that are
9 uninsured in our system. The majority of the
10 money goes towards the adults, that's eighteen
11 and over.

12 During this fiscal year, '17/'18, our
13 fiscal year ends June 30th, through May, not
14 including June, we've served about twenty-eight
15 thousand individuals, without counting June, of
16 which this year we did a lot more outreach
17 services, and those are peer support services
18 to connect people between systems, and we are
19 tracking individual connections with that, so
20 we have an additional twenty two thousand
21 outreach engagement types of units that we
22 have.

23 Services types funded, you see it there.
24 We have addiction receiving facility ARF and
25 JARF that was funded through June 30th, and now

1 it's privately funded. We have aftercare
2 assessment case management. We recently got,
3 received funding from DCF on a new CAT team
4 that was funded last fiscal year and procured,
5 and so that team started towards the end of the
6 fiscal year last year.

7 Care coordination teams, we have specialty
8 CCT teams that are made up of a licensed
9 clinician that oversees case manager and a peer
10 specialist together. They practice in
11 evidence- based practice called CTI, Critical
12 Time Intervention, and they focus on
13 individuals that are high risk high utilizers
14 that are transitioning from one high level of
15 care to another. And this is an initiative
16 that started about a year and a half ago, two
17 years, with funding that we received from DCF,
18 and previously we had started a pilot with a
19 smaller amount of money. We have three of
20 those teams in Broward County focusing on
21 substance abuse, on mental health, and care
22 coordinating services.

23 We have a central receiving center, or
24 system, funded at Henderson, that we received a
25 year and a half ago. This was going to be our,

1 going into our second year, full year, and this
2 is where people are dropped off by the police,
3 or hospitals, where people do not meet
4 criteria. This is focusing on adults only at
5 this point. And pretty much individuals are
6 referred there to be triaged, and to be
7 assessed for levels of care, and connected to
8 the community mental health centers in the
9 community.

10 We have clubhouses, drop in centers,
11 crisis stabilization units, crisis support. We
12 have a mobile crisis team in Broward County.
13 We have day/night treatment programs,
14 detoxification units. We have a FAIT team,
15 Family Intensive Treatment team that focuses on
16 the individuals that are in the child welfare
17 system that need mental health or substance
18 abuse services.

19 First episode team, this is for
20 individuals sixteen to thirty-five that need,
21 they have their first psychotic episode. It's
22 really a prevention program for people that are
23 beginning their process of becoming psychotic,
24 and so we try to get them into, they provide
25 services through this team to divert them from

1 the chronicity of the illness and try to get
2 them mainstream with their families into their
3 process of recover. We also purchase from the
4 providers flexible funds. We give them
5 flexible funds to be able to individually
6 provide whatever needs their treatment plan
7 identifies, which could be transportation, it
8 could be things that they need in order to
9 fulfill their recovery plan.

10 Information and referral, in-home
11 services, we provide out-patient therapy in the
12 office, but we also do in-home services, so
13 providers basically have teams that go into the
14 home and provide treatment in the home.
15 Intervention medical service, psychiatric
16 services, medication assisted treatment, that's
17 very opiate, opiate focused. Out-patient
18 outreach prevention, recovery, and peer
19 support, residential, supported employment, and
20 supported education for people that are in need
21 of assistance to get jobs or be successful in
22 school.

23 Supported housing and living, and
24 transition to independent process, which is a
25 life coach that we, we received, and it's an

1 evidence-based practice that we have, the focus
2 is on kids that are transitional age youth,
3 somebody was asking about that, ages fourteen
4 to twenty one is through a SAMHSA grant that we
5 receive through the Broward County, and we
6 practice and evidence based practice called
7 transition to independent process. And the
8 case managers can have lived experience, or
9 they could be professional case managers, and
10 they are trained on a specific practice.

11 And they're really a life coach, so kids
12 that usually do not want to engage in our
13 traditional mental health services really like
14 this, because they really have a life coach
15 that, that can go along with them. We have had
16 a great successful program with that, and I
17 think Ute was mentioning that, that that was
18 also a program that was offered in Hillsborough
19 County, that they're using that practice.

20 So, these are the different arrays of
21 services and who provides them, so we have,
22 these have the types of the emergency services
23 that we purchase from the system. Pretty much
24 we have children and adult mobile crisis team
25 through Henderson. Juvenile addiction

1 receiving facility through Fort Lauderdale
2 Behavioral Health Center. Crisis stabilization
3 through Henderson. Crisis Baker Act receiving
4 facility through Memorial University Pavilion
5 Fort Lauderdale Behavioral Health. Residential
6 detox, in-patient detox, in-patient mental
7 health services at Memorial.

8 We have an in-patient detoxification for
9 pregnant women with their children, where we
10 take all of the family into residential
11 services, not the father but definitely the
12 mother and the children. We have an
13 out-patient detoxification program at Memorial
14 for adults. Medical assisted treatment
15 programs at Memorial, Banyan, and BARC.

16 Children's Residential Services, we
17 purchase statewide in-patient services, which
18 is SIP placements for individuals that need
19 that level of care. This is a secured facility
20 for youth up to the age of eighteen or
21 twenty-one, depending on who pays for it,
22 whether it is Medicaid or us. And we purchase
23 that service for kids that have no insurance in
24 order to meet their needs.

25 We have -- we purchase residential level

1 two services from Covenant House, Here's Help,
2 and Concept House depending on the need.
3 Juvenile incompetent to proceed residential
4 services are usually offered through the
5 statewide contract in Twin Oaks, so we have
6 that available through the State.

7 Adult residential services, again we have
8 a short term, we purchase a few beds of
9 short-term residential treatment services for
10 forensic and few civil clients at the STAR
11 program at Citrus. Residential level one
12 forensic, level one is provided through
13 Henderson Behavioral Health. We also have not
14 secure residential level one provided through
15 Henderson Behavioral Health and Gulf Coast.
16 Level two is provided by Henderson and House of
17 Hope for co-occurring substance abuse, Archways
18 and Banyan. Residential level two for women
19 and their children at Susan B. Anthony, and
20 residential level two at BARC only for
21 substance abuse not co-occurring, and
22 residential levels three and four at Gulf
23 Coast, House of Hope and Archway.

24 So, there's different levels of
25 residential care, and people get in there based

1 on a tool that we use called, a level
2 assessment tool called the LOCUS, people have
3 to score the need for that level of care in
4 order to get in, and we basically are ensuring
5 that their progress and treatment is
6 appropriate on a monthly basis to make sure
7 that they're being discharged a appropriately
8 and there's a bed available for the next person
9 coming down the pike.

10 Children/youth nonresidential program,
11 these are all the providers that offer those
12 services in the network. We have a total of
13 thirty-one providers in our network. Adult
14 residential services, again this is -- I'm not
15 going to mention all of them, there's just the
16 list of services that are being offered.
17 Adult, children, and family support services,
18 this is very important. We talked about peer
19 specialists before. We believe in peer
20 specialists, because I think they've done an
21 awesome job in really enhancing our system of
22 care and integrating with our traditional
23 community mental health centers and service
24 array.

25 Peer support services, training, advocacy

1 for adult and children all right provided by
2 South Florida Wellness Network. It's a peer
3 run organization where everyone there is a
4 peer, and is trained and certified, and they
5 continue to provide training and capacity
6 building of our network. They train providers,
7 and they train peers to become peer
8 specialists.

9 We also have drop in centers where people
10 can come in and pretty much do whatever they
11 want to do, whether it's art, music, et cetera,
12 and develop other alternative ways of
13 expressing themselves. And we have 9 Muses,
14 the Rebel Center, and also Foot Print for
15 Success. Supported employment at various
16 facilities, and this is an evidenced base
17 practice using IPS, supported housing using
18 Housing First at Henderson.

19 These are all the evidenced based
20 practices that are being provided through our
21 network of providers, and we have trained
22 people on all kinds of things because we knew
23 that we needed, for example, trauma clinicians
24 for adults and children were, three years ago
25 we started the training process for all the

1 clinicians available, so we have motivational
2 interviewing, wellness recover action planning,
3 which is really focused on peer, it's a peer,
4 peer to peer approach, mental health first aid,
5 trauma focused CBT, which is for children
6 eighteen and younger, trauma incident
7 reduction, which is for youth, adolescents and
8 adults.

9 And all these are treatment, treatment
10 services to deal with trauma, resolving trauma.
11 Transition to independent process, which I
12 mentioned before. We also discovered another
13 evidence-based practice called moral reconnection
14 therapy that works very well with a criminal
15 justice involved individual, and we have now a
16 program with youth that works very well with
17 that.

18 Crisis intervention team, we are, we do
19 train police officers in becoming, law
20 enforcement officers in becoming trained on
21 CIT, supportive housing, IPS, FACT team
22 evidence-based practice, the critical time
23 intervention, of course the Locus and
24 (unintelligible) a level of care assessment.

25 In 2015/'16 we did a survey to find out

1 how many clinicians were practicing
2 evidence-based practices and delivering
3 services under an evidence-based practice, and
4 our network had eighty-seven, eighty seven
5 percent of our clinicians and supervisors who
6 are using one evidence-based practice or
7 another in their, in their service delivery.

8 New initiatives, of course we just started
9 this year with SDR grants in Medication
10 Assisted Treatment. We have a Community Action
11 Team; the CAT team is a new program for us last
12 year. We expanded our care coordination teams.
13 We started with care coordination being done by
14 peers supervised by a licensed clinician,
15 connecting people from state hospital
16 discharges to the community, and they were in,
17 reaching in to the state hospitals, and then
18 that worked out so well, and were doing so well
19 that that was expanded to now have peers
20 attached to detoxification centers and
21 receiving facilities that we contract with.

22 The Short-Term Residential Treatment
23 Program, which is a civil forensic, very small,
24 eight beds. The, let me see which one, what
25 else do we have here. We have a few -- we have

1 a primary behavioral health care integration
2 pilot that was funded through the health
3 foundation to try to connect primary health
4 with behavioral health. And we were talking a
5 little bit about, we got stuck in the data
6 connection when we were doing this pilot and
7 funding the data connection between primary
8 health and behavioral health.

9 Family Connection through Peer Recovery is
10 a federal grant that we receive to enhance the
11 quality of the care and the knowledge of the
12 child welfare case managers to understand
13 family dynamics so that they can help families
14 and divert people from the foster care system.
15 And that's part of our initiative with Child
16 Welfare Integration.

17 We do have a Maternal Addiction Program
18 that detoxifies pregnant mothers on opiates on
19 any trimester and is in collaboration with our
20 residential program for moms and babies. And
21 we have had a success of, I think it's
22 seventy-nine newborns drug free, born drug
23 free, whose moms were addicted to opiates, when
24 we started two years ago.

25 The Family Engagement Program is also

1 based with peers at BSO, Broward Sheriff's
2 Office. We co-locate there through Henderson.
3 Licensed clinicians, certified addiction
4 professionals and peer specialists, people that
5 have, these are women that have gone through
6 the process of either having their child
7 removed and being substance abusers that are
8 now doing well in recover, and we use them to
9 engage parents that are coming into the system
10 so that they can accept treatment and be
11 supported that way.

12 We have a Family Intensive Treatment Team,
13 which is a FIT team for parents that are
14 addicted to drugs that are going into the child
15 welfare system. The Power of Peers is a
16 program that I mentioned before, with peers
17 being discharged from the hospitals and now
18 being attached to receiving facilities and
19 detoxification.

20 Post-Arrest Diversion Program, we have one
21 of those in conjunction with the jail, where we
22 identify individuals that are being arrested,
23 and are identified with having mental health
24 problems. And we have a collaboration between
25 the state attorney, the public defenders, and

1 the provider, which is Broward Regional, and if
2 all is accepted these consumers are sent to
3 this program, they receive the supported
4 housing, supported employment, they receive
5 mental health treatment, and they also receive
6 moral resonation therapy in case management.
7 And the idea is to get their lives turned
8 around, and they pretty much, the state
9 attorney agrees to drop their charges. The
10 target is third degree felonies, and some
11 second degrees that are non-violent, for that
12 program, and we're doing pretty well with that.

13 And then the One Community Partnership is
14 the one that talks about the transition to an
15 independent, this is the program that funds the
16 transition to independent process. We through
17 that program also have the CLAS Standards
18 initiative, where we are, we have plans for
19 CLAS Standards, making sure that everybody
20 meets the cultural linguistic federal level of
21 requirements. We do trainings. And there's a
22 whole involvement of consumers in developing
23 the training, and we even have videos that we
24 have developed to educate the public on what
25 that is.

1 And then recently with the MSD shooting
2 the trauma trained clinicians have been
3 available to the community, the first
4 responders, the teachers, the students, to
5 offer services for treatment resolution. And
6 we also have funded a program through SHINE
7 that offers alternative therapies to survivors,
8 families, and first responders, and this
9 include trauma train, music therapists, art
10 therapists, drama therapists, and all of these
11 are working with the kids in the summer, and
12 the parents, to offer other ways of resolving
13 and processing their trauma.

14 Priority needs and gaps, what we have
15 identified through our network is that housing
16 and care coordination at the ME level and the
17 provider level are essential. We need more of
18 those services, and this housing and care
19 coordination is what helps people that are
20 coming out of those receiving facilities and so
21 forth, glue them with good discharge planning,
22 because then they can, they can, they can
23 really access the services that they need so
24 that they don't come back into the system
25 again.

1 We also need to sustain and increase the
2 managing entity operational integrity capacity.
3 We have a line item for our operations that has
4 stayed the same, and we need to make sure that
5 as our programs grow we also grow to be able to
6 provide technical assistance and oversight of
7 the network. FACT Team enhancement would be
8 beneficial. Short term residential peer
9 support services are important, to continue to
10 fund those. Supported housing project and flex
11 funds to fund the rents, and subsidy rents for
12 individuals is important. We don't have enough
13 affordable housing in Broward County, and so we
14 need more of that.

15 We are working on partnerships with the
16 medical, the Medicaid managed care plans to
17 develop better rates for the providers,
18 telemedicine. Anyway, I think you can read the
19 rest of our needs, they're a long list. If you
20 have any questions?

21 CHAIR: Okay, you got it. Okay, any
22 questions for Ms. Quintana? Yeah, Sheriff
23 Ashley.

24 SHER. ASHLEY: Thank you for your
25 presentation. I'm just trying to figure out,

1 in treating mental health patients is there a
2 predominant method, is it more medication,
3 pharmaceuticals, is it more counseling and
4 therapy, a combination of both, or something
5 other?

6 MS. QUINTANA: It's a combination of many
7 things that works. So, individuals need to be
8 assessed, and of course tried and tested for
9 the right medication. I think Ute talked
10 before about the fact that different
11 medications work different on different people.
12 But once the medication is secure, many times
13 even before you get to the medication you need
14 to really engage them, because people may think
15 that they don't have a problem, and so the
16 SPER, the peer supported initiatives with
17 trained peers are crucial in engaging folks
18 because what they do is they offer hope to
19 people that are really living very miserable
20 lives, right?

21 And those people basically come out and
22 say, hey, I was there three years ago, and
23 three years ago I as in jail, I was in the
24 state hospital, or I was turning in and out of
25 the detox units, or the, you know, the

1 receiving facilities, and look at me now, I'm
2 working, and I'm trained, and I'm able to help
3 you out. That light of hope that is instilled
4 through peers to people that are really
5 difficult to engage is a very important piece.
6 That's a first step, engagement. Then you need
7 to have an assessment, make sure that they're
8 on the right medications, that they have an
9 advocate, which could be the peer, to talk to
10 the doctor about this is not working well,
11 their signs and symptoms, and so forth, so it's
12 kind of like a navigator that helps a person
13 from their perspective to engage into
14 treatment.

15 And then finding out from that person what
16 is it that you would want in life, because it's
17 not necessarily what the case manager thinks,
18 or what the doctor thinks, it's what they want.
19 People will work for what they want, and so --
20 and that's part of all this evidence based
21 practice, it's like what do you want to, well,
22 I want to work, okay, so if you want to work
23 but you're really sick, we'll find, let's see
24 whether we can find you a job, and so in the
25 process of finding that person a job you, the

1 person realizes that, oh, my God, I just got
2 the best job of my life but I can't hold it
3 together, I can't think straight, I can't focus
4 straight.

5 And that's where you say, well, maybe we
6 need to adjust your medication, or maybe we
7 need to get some therapy for your, people have
8 trauma, and trauma gets triggered, right, so
9 maybe we need to go to a trauma therapist and
10 get you -- so it's through the goals of people,
11 what they want to do, and usually with a peer
12 advocating because they speak the same language
13 is how you can get people with all the supports
14 that they need.

15 So, it's about engagement, it's about
16 having an advocate and a peer. It's about
17 medication, and it's about reaching the goals
18 that you want to reach as soon as possible and
19 providing the supports in order for you to be
20 successful in your goals.

21 SHER. ASHLEY: Thank you. I just want to
22 bring to the attention of the commission the
23 Citizens Commission on Human Rights of Florida,
24 are you familiar with that organization?

25 MS. QUINTANA: No.

1 SHER. AHSLEY: Well, they got out --
2 they've published a number of reports recently
3 addressing medications, and specifically
4 psychotropics, and the dangers associated with
5 psychotropics, and side effects, and that's why
6 my question in what is the predominant method
7 of treating mental, mental health issues, is it
8 more medication, or more therapy, or
9 counseling. Do you see any dangers with
10 prescriptions being abused, or overused, or
11 over prescribed, or --

12 MS. QUINTANA: Sometimes individuals are
13 over medicated, and an advocate can come and
14 say, oh, this person is sleeping all the time,
15 they can't function enough. And, you know, the
16 doctors see the patient fifteen minutes and
17 they do the prescription. Unless someone that
18 is a reliable reporter can come back to the
19 next doctor's visit and say, you know, doctor,
20 this person is sleeping most of the time, this
21 persons' medication is not working well, this
22 person -- you know, you need to -- you need to
23 be -- and sometimes the person who is receiving
24 the medication, they can't tell, or they can't
25 report to the doctor what's going on, so it's

1 really a combination of the relationship with
2 the doctor. And of course, doctors will adjust
3 medication down, or they, so it's a combination
4 of those things. So, it's -- I think that part
5 of it has to do with how, how do we communicate
6 with the doctor. For some -- for a lot of the
7 mental illnesses people do need some
8 medication. Not everybody needs medication for
9 everything. Some people go to therapy and work
10 it through other behavioral, you know, other
11 behavioral health, or behavioral interventions.
12 So, it's a combination depending on what, what
13 your diagnosis is.

14 SHER. ASHLEY: And thank you for, for the
15 benefit of this commission. If you've not seen
16 or read these reports I would highly recommend
17 them. Their claim is pretty outrageous, that
18 the vast majority of our mass shooters have
19 been under the influence of psychotropics
20 before, during, or after, not after, but before
21 or during. And some pretty eye-opening claims
22 with a lot of reference, medical references and
23 doctor's claims, and the like, so it may be
24 worth our while to examine is, are we over
25 prescribing medications for mental, mental

1 health issues.

2 MS. QUINTANA: Okay.

3 CHAIR: Any other questions for Ms.
4 Quintana? Okay, well, we thank you very much.
5 We appreciate you being here. I believe Judge
6 Leifman is here. Why don't we take a quick
7 ten- minute break, and I've got 3:06, we'll
8 come back at 3:16, ten minutes. Thank you.

9 MS. QUINTANA: Thank you.

10 (Thereupon, a recess was had and the meeting
11 continued as follows:)

12 CHAIR: All right, we're going to go ahead
13 and get started here with a presentation on the
14 Baker Act from Judge Steve Leifman. Judge
15 Leifman is from Miami-Dade County, and as
16 you'll hear and know he's a brilliant expert in
17 this area, and somebody that we get a lot of
18 information from on the Baker Act, and mental
19 health in general. Judge Leifman, welcome, and
20 thank you for being here.

21 JUDGE LEIFMAN: Thank you very much, Mr.
22 Chairman. Members of the commission, good
23 afternoon. My name is Steve Leifman, and I
24 Chair the Florida Supreme Court's Task Force on
25 Mental Health and Substance Abuse issues, and I

1 want to thank you very much for the opportunity
2 to be here, but more importantly I want to
3 thank all of you for this very important work,
4 though I know all of us wish it really wasn't
5 necessary.

6 Florida has a very interesting and
7 somewhat tortured history when it comes to
8 providing treatment and services to people with
9 serious mental illnesses. Many of the current
10 problems and weaknesses of our community mental
11 health system can actually be traced back to
12 historical events that have shaped public
13 policy and attitudes towards people with mental
14 illnesses in the state.

15 During the early part of the nineteenth
16 century Florida actually exported people out of
17 the state who had mental illnesses. We sent
18 them to Georgia and South Carolina and paid
19 those states \$250 per person to house them for
20 us. We were one of the last states in the
21 United States to open up a state hospital, and
22 that was, the first hospital actually was
23 opened in Chattahoochee, which previously had
24 been a civil war armory.

25 With little effective treatments at that

1 time, we're talking now 1876, people were
2 warehoused in very difficult and inhumane
3 conditions. And this went on for almost a
4 hundred years. It wasn't until 1971 when the
5 legislature passed into law the Florida Mental
6 Health Act, which went into effect the
7 following year in 1972. This Act brought a
8 dramatic and comprehensive revision of
9 Florida's ninety-seven- year-old mental health
10 laws, and substantially strengthened the due
11 process and civil rights of persons in mental
12 health facilities, and those that were of the
13 aid of emergency evaluations and treatment.

14 The Act, usually referred to as the Baker
15 Act, was named after Maxine Baker, a former
16 state representative from Miami who had
17 sponsored the legislation. The intent of the
18 legislation at the time was to encourage
19 voluntary commitments, as opposed to
20 involuntary commitments. Before the Baker Act
21 was enacted a person could be placed in a state
22 hospital with the signatures of the three
23 people and a county court judge indefinitely.
24 There was no process. People were locked away.
25 In fact, you could be as young as twelve years

1 old and put in a state hospital with adults
2 indefinitely until for whatever reason they
3 decided to release you.

4 And so, what the Baker Act really did was
5 prohibit the indiscriminate admission of
6 persons to state institutions, or the retention
7 of people without just cause. Its mandated
8 court appointed attorneys, it established
9 patients' bill of rights, it prohibited the
10 placement of people with mental illnesses in
11 jails unless the committed a criminal act. And
12 at the time it really was considered around the
13 country as one of the most important landmark
14 pieces of legislation.

15 It also established the criteria for
16 involuntary examination, and involuntary
17 placement at a state psychiatric hospital.
18 Now, I want to be really clear, because I think
19 there's a lot of confusion of what people think
20 a Baker Act is. And so, when someone is,
21 quote/unquote, Baker Acted, what that really
22 means is that they are getting admitted for an
23 examination only. They are not getting
24 admitted for an involuntary commitment, it's
25 only the first step. And before you can even

1 be taken to a Baker Act facility, or a crisis
2 stabilization unit, you have to meet criteria
3 to even get in the door. And this is what
4 causes a lot of confusion among law
5 enforcement, and other people that are doing
6 it.

7 So, in order for a person to be taken,
8 just taken to the receiving facility for an
9 examination, they must meet three criteria.
10 One, there has to be a reason to believe that
11 the person actually has a diagnosable mental
12 illness, meaning they have to be diagnosed, or
13 thought to be diagnosed with something like
14 schizophrenia, bi-polar, or major depression.
15 If they are under the influence of drugs or
16 alcohol that does not count. If they are
17 developmentally disabled that does not count.
18 And so, if someone is developmentally disabled
19 and acting out, or under the influence, and are
20 taken to a Baker Act facility for an
21 examination, they're going to be out in five
22 minutes. That's the first criteria.

23 The second criteria just to get in for an
24 exam is that because of their particular mental
25 illness they have refused voluntary

1 examination, or they unable to determine
2 whether an examination is necessary, so they
3 can't be voluntary. And number three, without
4 care the person is likely to suffer from
5 neglect resulting in real and present threat of
6 substantial harm that can't be avoided through
7 the help of others, or there is a substantial
8 likelihood that without care or treatment the
9 person will cause bodily harm to self or others
10 in the near future, as evidenced by their
11 recent behavior.

12 And this is just what's required to get
13 him in the door for an examination, and so what
14 often happens is a police officer may take them
15 in because they're acting out in a way that may
16 be dangerous to the community, but they don't,
17 or can't understand, they're not trained
18 doctors, and so when the person gets to the
19 facility they'll often see the person leave by
20 the time they're walking out to their car.

21 It also raises a lot of frustration from
22 the providers because they end up bringing a
23 lot of people that are not meeting criteria in
24 a system that's already under resourced and
25 over-burdened, and so they're trying to deal

1 with people that they don't even have legal
2 authority to examine. And so, if the police
3 officer hasn't been adequately trained, or
4 properly trained a program like CIT, which I
5 don't know if you've had much discussion about,
6 that stands for Crisis Intervention Team
7 Training. It's a forty-hour training program
8 that is really doing a wonderful job around the
9 state, and I'm going to talk a little bit more
10 about it later, but it trains law enforcement
11 officers how to understand this criteria, how
12 to deescalate a situation, how not to arrest
13 someone, and where to take them if they meet
14 that criteria.

15 Now, an involuntary examination can be
16 initiated by one of three ways. And so, this
17 is important too because not everybody can send
18 someone in involuntarily. A circuit court
19 judge, not a county court judge but a circuit
20 court judge, can enter what we call an ex-parte
21 order that it based upon sworn testimony that
22 directs a police officer to then pick up the
23 individual and take him to a Baker Act
24 facility.

25 Second, any sworn law enforcement officer

1 in Florida also has the authority to
2 involuntarily Baker Act someone for an
3 examination only based upon what they see, and
4 in their discretion. And third, a physician or
5 a clinical psychologist, a psychiatric nurse or
6 a clinical social worker as defined by statute
7 may execute what we call a professional
8 certificate stating that they have examined an
9 individual in the previous forty- eight hours,
10 and they believe this individual meets the
11 criteria for an examination.

12 Now, interestingly enough over half, about
13 sixty percent of the involuntary examinations
14 were based on evidence of harm only. And I'm
15 going to break that down in a minute. So, harm
16 can either be to self or to others, and so
17 about sixty percent of the involuntary
18 examinations come in fall under that category.
19 About one quarter of the cases that come in for
20 an involuntary examination were based on both
21 harm and self-neglect, and less than ten
22 percent were based on self-neglect alone,
23 meaning that, and I'll talk about the standard
24 in a minute, but that you were self-neglecting
25 yourself so badly that you were putting

1 basically your life at risk.

2 Now, they break down the harm type, which
3 is very interesting as well. More than half,
4 about fifty six percent of all the involuntary
5 examinations that were based on harm were harm
6 to self, so mostly people that were at some
7 type of suicidal risk were coming in for an
8 involuntary examination. About twenty one
9 percent of all the involuntary examinations
10 were based on both harm to self and others, and
11 only about five and a half percent of all
12 involuntary examinations were based on only
13 harm to others.

14 So, assuming an individual in fact meets
15 the initial criteria to be examined they have
16 to be examined almost immediately without delay
17 by a clinical psychologist or a physician, and
18 as you know they can be held no longer than
19 seventy-two hours. Within the seventy-two-hour
20 period one of the following must happen.

21 Number one, the person must be released unless
22 they're charged with a crime. The person must
23 be released for out-patient treatment. The
24 person must be asked to give expressed and
25 informed consent to take voluntary treatment,

1 or a petition for involuntary placement must be
2 filed with the circuit court by the
3 administrator of that facility.

4 If the petition is in fact filed by the
5 receiving facility there must be clear and
6 convincing evidence that the person has a
7 mental illness, like I described earlier, so it
8 can't be because they have a sociopathology
9 issue, under the influence, or some kind of
10 substance use disorder, it has to be an actual
11 serious mental illness, and they have refused
12 voluntary placement, or they're, they're unable
13 to determine whether placement is necessary,
14 that he or she is incapable of surviving alone
15 or with the help of others, and without
16 treatment they are likely suffer from neglect
17 which poses a real and present threat of
18 substantial harm to his or her well-being, or
19 there is substantial likelihood that in the
20 near future he or she will inflict serious
21 bodily harm to the self or others, as evidenced
22 by recent behavior causing, attempting, or
23 threatening such harm, and all available less
24 restrictive treatment alternatives which would
25 offer an opportunity for improvement to his or

1 her condition have been judged to be
2 inappropriate.

3 Now, having said that, the vast majority,
4 and remember we had about two hundred thousand
5 involuntary examinations last year in Florida.
6 More than half of them, just over a hundred
7 thousand of them were initiated by police
8 officers. I want to put that into some context
9 as well. It's more than the total number of
10 arrests that police made last year for
11 burglary, grand theft auto, and assault
12 combined, are the number of law enforcement
13 involuntary examinations in this state, which
14 shows you how much the police are involved in
15 this aspect of the issue.

16 The vast majority of these individuals are
17 either released, or they agree to voluntary
18 treatment. Last year only one thousand seven
19 hundred eighty-seven people were in the state
20 civil psychiatric hospital. We had two hundred
21 thousand involuntary exams last year, all
22 right, a mere fraction, less than one percent
23 of the people that went in for an involuntary
24 examination in Florida were adjudicated,
25 meaning there was a court hearing and a judge

1 determined they should be involuntarily
2 committed to a state hospital. It's a
3 fraction. And it also, I'm going to talk about
4 how that affects some of the gun laws that were
5 passed, because it's left a gaping hole because
6 of that.

7 Now, while there may be more people than
8 the seventeen hundred that were actually
9 committed what happens is if you are committed
10 by the court and there is a not a bed available
11 the individual languishes at the crisis
12 stabilization unit until a bed opens up, which
13 often can be months. The crisis stabilization
14 unit does not get paid while the person is
15 waiting for that bed to open up, so guess what
16 happens in the vast majority of those cases?
17 The person gets tired at staying at a CSU,
18 which is a small facility inappropriate for
19 long term care, they switch to voluntary
20 status, they finally agree to take the pill,
21 the shot, the medication, and then they get
22 released back to the street without very few
23 services.

24 Like the sheriff mentioned earlier that is
25 one of the vexing problems of this, of this

1 situation. Florida does a pretty decent job of
2 getting people examined for an involuntary
3 hospitalization, but a very poor job of any
4 follow up. I mean this is a sad commentary on
5 our situation, but two weeks ago I took my dog
6 to the vet. He had a minor little fungus that
7 was easily treated. It was on a Saturday.
8 Monday morning the veterinarian's office called
9 my house to see how my dog was doing, wanted to
10 know if he needed any extra assistance, or
11 anything else they could do.

12 Do you want to take a guess how many
13 people who left a crisis stabilization unit
14 that had been deemed imminently dangerous to
15 self or others got a call when they left the
16 facility? We're treating our dogs better than
17 we're treating our fellow citizens in our
18 state. And while the science, research, and
19 treatment for mental illnesses has
20 significantly changed since the Baker Act was
21 passed almost fifty years ago the criteria for
22 involuntary hospitalization in Florida has
23 stayed the same.

24 And unfortunately funding for mental
25 health services in Florida has remained near or

1 at the bottom in the United States. It was
2 discussed, discussed earlier, we are between
3 forty ninth and fifty first per capita in
4 mental health funding, which makes it very
5 difficult to serve this population. In fact,
6 only about twenty something percent of
7 Floridians who need mental health services are
8 able to get it. We should think about it this
9 way. Could you imagine if you had cancer, and
10 we told eighty percent of the people that had
11 cancer that they couldn't get access to
12 services because we only have enough money to
13 serve twenty percent? That's what's happened
14 here.

15 We have forgotten that these are real
16 organ illnesses, they are illnesses of the
17 brain. It is an organ. It's no different than
18 heart disease, diabetes, cancer. In fact,
19 what's more significant is that the recovery
20 rates for people with serious mental illnesses
21 is actually better than for people with heart
22 disease and diabetes. The key is getting early
23 treatment, access, and services to they can get
24 into recovery and stay in recovery.

25 Generally, people with serious mental

1 illnesses are no more dangerous than the
2 general population, and on medication they are
3 actually much less dangerous than the general
4 population without a mental illness. That
5 doesn't mean that we should ignore the people
6 that are exhibiting signs and symptoms, and we
7 need to do a better job to make sure that we
8 get them the services they need, and make sure
9 that they do not get easy access to firearms.

10 Florida is also what we call a minority
11 state. We are one of I believe four states
12 that has the criteria for involuntary
13 examination and involuntary commitment in the
14 United States. And I don't believe we do that
15 because we are this great civil libertarian
16 state. I believe we do it because we're cheap.
17 And if we have to acknowledge that more people
18 need services we're going to have to
19 acknowledge more money to pay for those
20 services.

21 And so we have been incredibly restrictive
22 in allowing people to get access to baker Act
23 services, and I think really it's time that we
24 start to look at some of the other states that
25 are doing a better job in this arena, broaden

1 our criteria, but I will tell you we could have
2 the most liberal criteria in the country and it
3 will be useless if we don't improve that
4 continuity and continuum of care when people
5 leave those services, so if you're going to
6 broaden the Baker Act, which I think you need
7 to do, we also have to make sure there is a
8 corresponding improvement on what we do with
9 the individuals when they leave that system.

10 I'd also like to briefly address some of
11 the loopholes that remain in both the Baker Act
12 and for individuals that have been adjudicated
13 incapacitated in guardianship proceedings,
14 which I'm sure you have not even discussed.
15 There's a whole other section in the law for
16 people that have become what we call
17 incapacitated, family members that may have
18 dementia that are incapable of caring for
19 themselves. So, under Florida law, for
20 instance, if you have been incapacitated by the
21 court, meaning that a guardian is going to be
22 appointed to look out for your best interests,
23 you can no longer get married. However, you
24 can still go out and buy a gun, and keep a gun.

25 I think that something needs to be

1 adjusted. In fact, two days ago in USA Today
2 on the front page there was a fascinating
3 article. About nine percent of the households
4 in the United States have family members
5 sixty-five years or older that have dementia.
6 Forty five percent of households with
7 individuals forty-five years or older also
8 possess firearms, and so there is real concern,
9 and that's what the article was about, people
10 with dementia accidentally shooting, killing
11 spouses, neighbors, postal workers, because
12 they get scared, they don't know what's going
13 on, and they still have access to their
14 firearms.

15 In 2018 the legislature enacted some
16 really wonderful laws that were designed to bar
17 people with mental illnesses from accessing or
18 possessing guns, but what they did is they kind
19 of left a big hole, and it goes back to what
20 were just talking about a moment ago. So, what
21 the law says, if you're adjudicated mentally
22 defective, quote/unquote, or committed to a
23 mental institution, you can no longer possess
24 or own a firearm or get a concealed firearm
25 permit. Only one percent of people out the two

1 hundred thousand that are going into our system
2 are adjudicated. The vast majority are
3 voluntary, and so it's left a hole.

4 So, if you come into a Baker Act facility,
5 you meet the first criteria to be examined.
6 You then go through the process where a doctor
7 has found that you meet the criteria under
8 dangerousness, but you decide to voluntarily
9 take medication, that law does not apply to
10 you, and you still have access to purchase and
11 maintain a firearm.

12 Now, we fixed part of that on the
13 purchasing of the firearm, but they didn't
14 extend the same law that was passed three years
15 ago that closed the loophole for people that
16 moved to a voluntary status, and so one of the
17 recommendations that you may want to consider
18 is extending what we did on the purchase of a
19 firearm for people that are switching to
20 voluntary status.

21 Now, having said that there's still a
22 problem with the implementation of that law.
23 There was an article a few weeks ago that said
24 about seventeen percent of people who should be
25 on that list have not gotten on the list

1 because of delays between the providers sending
2 the information to the Clerk of Court and the
3 Clerk of Court in the circuits not
4 appropriately getting those names on the list.
5 In fact, in the article they said that about
6 fifty-seven hundred people who should have been
7 on the list and stopped from purchasing
8 probably bought firearms during that period
9 because they didn't get on there quickly
10 enough. So, there needs to be some oversight
11 in that system, there needs to be some
12 accountability that needs to be added to make
13 sure that wonderful law is actually being
14 implemented appropriately.

15 Now, on a positive note there have been
16 some very promising practices going on around
17 the state with our law enforcement,
18 particularly with the rapid expansion of crisis
19 intervention team policing. And I'll give you
20 a classic example from my own community. In
21 Miami-Dade County we now have the largest
22 trained squad of police officers in CIT in the
23 United States. We have over six thousand
24 officers at all thirty-six police departments
25 in Miami-Dade County.

1 But it's not enough just to train the law
2 enforcement officers, we also have trained all
3 of our 911 call takers so when a call comes in
4 the call taker knows to start to ask questions
5 if the case involves someone with mental
6 illness. If it does the dispatcher makes sure
7 a trained officer gets dispatched to the scene,
8 that is walking into a situation they
9 understand, and they're more equipped to handle
10 the situation. We also set up a four-hour
11 training program for every police chief in
12 Miami-Dade, and their majors, so that we can
13 even train them on how to run a CIT program and
14 coordinate it.

15 We have a liaison officer appointed at
16 every single police department in Miami-Dade,
17 and every station of Miami-Dade police
18 department in the City of Miami that meet on a
19 quarterly basis with our CIT coordinator, our
20 providers, and our managing entity. It is the
21 most amazing thing to watch because the level
22 of collaboration and coordination in the
23 largest county, in Miami-Dade County, stuns me
24 in a wonderful way every single day, and it
25 empowers the police officers to do their work.

1 And so, if they have a case where they've
2 gone out two or three times and they don't feel
3 it's being addressed adequately they report it
4 to the liaison officer. The liaison officer
5 then take that information to the quarterly
6 meeting, or picks up the phone and calls my
7 coordinator, who may call me, who I may have to
8 call who I have to call, and immediately we
9 intervene, immediately we make sure the system
10 is working.

11 Between 2010 through 2017 we keep data on
12 every single call the City of Miami and Miami-
13 Dade Police Department makes, CIT call, because
14 they handle about sixty percent of our mental
15 health calls. They handled eighty-three
16 thousand four hundred twenty-seven mental
17 health calls, and out of the eighty-three
18 thousand four hundred twenty-seven calls they
19 only made a hundred forty nine arrests. Our
20 police shootings almost stopped. Our police
21 injuries almost stopped.

22 And they're making sure people are getting
23 taken to a Baker Act facility if they meet
24 criteria, and if not, they try to hook them up
25 with other services. And if there's other

1 problems they work with us on a regular basis,
2 and we coordinate all of that activity. Most
3 of this is about communication. We've had a
4 couple very serious situations in our community
5 that could have turned into really horrible,
6 horrible situations, but because of the level
7 of collaboration and cooperation, and
8 empowering our police officers to know who to
9 call twenty-four hours seven days a week, we've
10 been able to intervene in some situations that
11 fortunately have never made the news. And the
12 outcomes have been surprisingly positive with
13 the two individuals I'm thinking about who are
14 now in recovery back home, and under intensive
15 treatment. So, it can be done.

16 So, in summary what I'd like to say is,
17 number one, Baker Acting someone only means
18 they are being taken in for an examination, and
19 they can only get there if they meet criteria.
20 It doesn't mean they're being committed to a
21 hospital. Our criteria for examination and
22 involuntary placement is almost fifty years old
23 and does not reflect modern science, research,
24 or medicine, and should be broadened, like most
25 states have done, so long as we improve our

1 continuity and continuum of care.

2 Florida needs more civil state psychiatric
3 hospitals so when people do meet criteria they
4 don't languish at a crisis stabilization unit
5 and figure out a way to get out quickly by
6 taking a pill, but get into the hospitals that
7 they need so that we can make sure that they
8 get the services they need.

9 We need to close the remaining loopholes
10 in the Baker Act, and then to guardian, excuse
11 me, the guardian cases for individuals that are
12 incapacitated. We need greater enforcement for
13 the mental health providers and the clerk of
14 courts to make sure that they're reporting the
15 information once they have it, and so it
16 doesn't get delayed, and people can't purchase
17 firearms that should not be able to.

18 We also need to work with our insurance
19 industry. One of the biggest problems in our
20 mental health system in Florida is we do not
21 have insurance parity, and so what happens is
22 people who have insurance can't get mental
23 health care with their insurance providers, and
24 they get pushed into the public mental health
25 system that's already overburdened and under

1 resourced, making it more difficult for more
2 people to get access to care.

3 And we also need to do a lot more in the
4 arena of trauma. Trauma is physiological.
5 It's not an emotional response. We all have
6 this little thing in our bodies called the
7 pituitary gland, and the pituitary gland -- and
8 you're like why is a judge talking to me about
9 a pituitary gland. This is really important.
10 The pituitary gland is part of your warning
11 systems, so if you're a police officer and you
12 go out to an accident where people have been
13 killed in a car accident the pituitary is going
14 to send a message to the adrenaline, and the
15 adrenaline is going to release a chemical
16 called cortisol, and it's your flight or fight
17 mechanism, and it's going to tell you to leave.

18 But if you're a law enforcement officer,
19 or if you're a soldier in active duty, you
20 can't leave, and so what happens is the
21 cortisol continues to fire, and it overdoses
22 the brain, and it permanently alters the brain
23 activity, and it causes PTSD. It explains why
24 last year more police officers died in the line
25 of duty, excuse me, died by suicide than in the

1 line of duty. It explains why law enforcement
2 officers have some of the highest divorce
3 rates, suicide rates, substance abuse rates,
4 and domestic violence rates, because they
5 suffer from very serious trauma issues.

6 My CIT coordinator gets a hundred fifty
7 calls a month from police officers that we have
8 trained for their own personal mental health
9 issues. They will not, and do not want to go
10 to their departments for help, and so we've
11 actually had to set up a system for them to get
12 help outside the department with the
13 department's permission to make sure that they
14 get treated, and it's helped.

15 But you have to understand ninety two
16 percent of all the women in jail and prisons in
17 the United States with a serious mental illness
18 were sexually abused as children. A young
19 brain that is overdosed with cortisol is
20 damaged even more than an adult brain. Seventy
21 five percent of men who are in the jail and
22 prison with serious mental illnesses also have
23 very serious trauma issues. So, one of the
24 recommendations that I hope you are able to
25 look at and make is that every pediatrician in

1 Florida should be screening for trauma, and our
2 schools should be training out teachers how to
3 identify kids that are showing signs and
4 symptoms of serious mental illness.

5 The American Psychiatric Association
6 Foundation, whose Board I serve on, has a
7 program called typical or troubled, question
8 mark, and it teaches teachers how to identify
9 kids that are showing signs and symptoms. We
10 wait too long, and the longer these illnesses
11 go untreated the more damage there is to the
12 brain, the more expensive it is, and the more
13 dangerous situations become. And so, if we
14 start to screen earlier we will get much better
15 outcomes, and we will avoid some really
16 horrific situations.

17 Thank you, I'll be happy to answer any
18 questions that you may have.

19 CHAIR: Judge, do you know of any, you
20 mentioned some other states, Florida is behind,
21 fifty years old in the Baker Act, off the top
22 of your head are there any state laws existing
23 that you would recommend we look at for models
24 for where, where we should go?

25 JUDGE LEIFMAN: Our supreme court has

1 looked at about four that we like. One of them
2 in particular is Wisconsin. And all these laws
3 have been upheld by their supreme courts, so
4 they've passed constitutional muster. You
5 know, I think what you want to look at when
6 you're looking at the Baker Act, you want to
7 look at where the science is. And so, we know
8 that when someone is in a psychotic episode the
9 longer it goes to get them out of that episode
10 the more likelihood there's going to be
11 permanent brain damage. So, if you have
12 someone that's psychotic but may not be what we
13 consider imminently dangerous to self or others
14 we want to take a look at that individual and
15 make sure they get treated so that they are not
16 maintaining the illnesses, so they don't get
17 permanent brain damage.

18 You know, we know that when kids are doing
19 bad things with animals that can be an
20 indication of something serious, so maybe
21 harming or killing animals could be an added
22 criteria. And the third one that we find our
23 magistrates get frustrated with is you may have
24 somebody at home that has destroyed the house,
25 but they haven't made a direct threat against

1 any individual in the house so they're not
2 meeting criteria. So, maybe the destruction of
3 property can be an added piece to the Baker Act
4 that would significantly strengthen the
5 magistrate or judge's hand to be able to
6 involuntarily commit.

7 Commissioners, any questions for Judge
8 Leifman? No, okay.

9 JUDGE LEIFMAN: Can I just touch upon one
10 question that was asked earlier about
11 medication? There are -- there is study out of
12 Harvard a year or two ago that said that most
13 people that were getting arrested that had
14 serious mental illnesses were not on
15 medication, so I think the data really suggests
16 that the medication actually reduces people's
17 arrest rates, and it's not necessarily that
18 they were on medication when they did something
19 bad.

20 Now, having said that, the medications can
21 have some very serious side effects. They can
22 cause diabetes, weight gain, shaking, and so
23 one of the problems that we have in Florida is
24 the formularies that are used often are the
25 older less expensive medications with more side

1 effects, and so it's harder to get people to
2 take medication if they know they're going to
3 get these really bad side effect. So, we want
4 to make sure the best medications are available
5 to people, but we also know that using too much
6 medication for too long, there's a recent study
7 that shows that it may actually shrink brain
8 tissue, and so it's really important that when
9 someone is in psychosis you get them out of it
10 as quickly as you can, and have a really good
11 doctor who understands these issues back down
12 on the medication so they make sure that its
13 done appropriately. All right.

14 CHAIR: Senator Book, go ahead.

15 SHER. ASHLEY: Can you reference that
16 study?

17 JUDGE LEIFMAN: Pardon?

18 SHER. ASHLEY: You referenced that study
19 as what?

20 JUDGE LEIFMAN: I'll send it to you.

21 SEN. BOOK: Thank you, Mr. Chair. And
22 thank you, Your Honor, for being here and
23 sharing all of your wealth of knowledge with us
24 today. One of the things that the Chair and
25 the commission has talked a lot about today is

1 the delta of the gap in services of individuals
2 who may be leaving these CSUs and need more
3 help. I had the privilege of visiting with you
4 and some of the jail gap diversion programs
5 that you have started in Miami-Dade, that while
6 we have a great amount of resources in Broward
7 County aren't necessarily being utilized, so
8 could you just speak to some of those to
9 enlighten the commission?

10 JUDGE LEIFMAN: Sure. We have a very
11 sophisticated pre and post arrest diversion
12 program. The pre-arrest is CIT, which I
13 already mentioned, and we have three post
14 arrest diversion programs. So, if anybody in
15 Dade County is arrested they are immediately
16 screened. The jail uses an updated screening
17 tool, and we don't have corrections staff do
18 it, we actually have a medical staff do the
19 screening at the jail.

20 If there's an indication that the person
21 has a serious mental illness they see a
22 psychiatrist that day. The psychiatrist does a
23 full assessment, and if they feel they meet
24 criteria under the Baker Act they do a
25 professional certificate that I mentioned

1 earlier, and within three days of the arrest of
2 the misdemeanor they're blood tested, we make
3 sure they have no communicable illnesses, they
4 are then transported to a crisis stabilization
5 unit. And because as I read the criteria under
6 the Baker Act they have a criminal charge
7 pending the seventy-two hours does not apply,
8 so we reset the case in about two weeks, which
9 is really what most of these individuals need
10 for stabilization.

11 They don't necessarily need long term
12 hospitalization, and they don't need an hour at
13 a crisis unit, a couple weeks really seems to
14 make all the difference in the world. They
15 begin to stabilize. We send a member of our
16 team to go visit with them. If they agree to
17 go into our program, which about eighty percent
18 of them do, they are not re-booked, they are
19 picked up by our Department of Corrections and
20 they are taken directly to the courtroom.

21 When they get to the courtroom there is a
22 peer specialist waiting for them. I have eight
23 peers that work for the court, four of them
24 graduated from our program. The county has
25 provided us a car. We have their actual

1 medication in court waiting for them. We have
2 clothes. We have food. We have begun the
3 Medicaid benefit process so that we can get
4 them on federal benefits, and we can get them
5 housing and treatment. We have housing
6 available for them. And then the peer drives
7 then where they're going to be sleeping that
8 night.

9 They will get picked up, and they will be
10 brought back to court when they need to come
11 back in court, but during the period they're
12 out of custody they have to go to a day
13 activity program, they have to go to treatment,
14 and they have to stay on their medication. And
15 then they start to come in front of the court,
16 and as they begin to recover we set them on a
17 Friday late afternoon calendar where we monitor
18 their progress and depending on the charge and
19 priors in most cases the state attorney will
20 drop the charge like any pretrial diversion
21 program.

22 Our recidivism rate among our misdemeanor
23 population went from seventy two percent to
24 twenty. It worked so well that the state
25 attorney allowed us to expand it to felony

1 cases, where we do a similar program for them
2 on non- violent felony cases. That program has
3 saved the county sixty-eight years of jail bed
4 days. When we started our mental health
5 diversion program in 2000 Miami-Dade County had
6 a hundred eighteen thousand arrests per year.
7 This year we're down to fifty-six thousand
8 arrests. We're less than most counties in
9 Florida.

10 Our jail audit has been cut almost in
11 half. We closed one of our main jails, at a
12 real savings of \$12 million a year. And
13 thankfully to the good people of Dade County,
14 and my County commission and mayor, they're
15 reinvesting about \$42 million of the dollars
16 we've already saved them, and we're now
17 constructing, hopefully we'll begin in a week
18 or two, the first of its kind in the country, a
19 mental health diversion facility for the most
20 acutely ill that keep recycling the deep ended
21 system.

22 Florida Mental Health Institute at the
23 University of South Florida has the ability to
24 tell a community who the highest utilizers of
25 criminal justice and mental health services are

1 in their community, so we send the names of
2 thousands of people that had been arrested in
3 Dade County over a five-year period who we knew
4 had serious mental illness. And we thought,
5 okay, we have huge prevalence in Dade, they'll
6 narrow it maybe to a thousand, fifteen hundred
7 people, but that will be a good start. They
8 actually have, just so you understand, live
9 data of all the FDLE records, all the Baker Act
10 records, all the Medicaid and Medicare records.

11 They narrowed down these thousands of
12 people to ninety-seven in Miami-Dade County,
13 primarily men, primarily diagnosed with
14 schizophrenia, primarily co-occurring and
15 homeless, who over a five year period these
16 ninety seven people were arrested twenty two
17 hundred times, they spent twenty seven thousand
18 days in the Dade County jail, thirteen thousand
19 days at a Baker Act facility, or a crisis
20 stabilization unit, or a hospital, cost tax
21 payers \$13.7 million, and we got nothing for
22 it.

23 And so, this facility that we're
24 constructing will be for this most acutely ill,
25 because part of the problem, is you have to

1 think about these as mental illnesses, it's
2 plural, and there's different levels of acuity
3 of these illnesses. There is no capacity
4 anywhere, it's not just Florida, for that
5 really high utilizer population that's very
6 sick. The system is painfully fragmented,
7 painfully under resourced, and very difficult
8 to access, because remember most crisis
9 stabilization units, most community mental
10 health providers, they were developed when most
11 people in Florida and elsewhere were still in
12 hospitals. They were never really designed for
13 the most acutely ill, and we're not asking them
14 to do more than they can do without the
15 resources to do it.

16 And so, the building will really be a mid-
17 level intensive level of treatment that will be
18 a one stop shop that will have what we consider
19 the fourteen essential elements that people
20 that are that sick need to recover in one
21 place. And it will be a medical home model, so
22 we'll have primary health and psychiatric
23 services, crisis unit, short term residential
24 facility, a day activity program run by people
25 with mental illnesses to teach

1 self-sufficiency. It has a magnificent kitchen
2 for a culinary supportive employment program.
3 We'll have a courtroom in there so that we can
4 administer their cases, or Baker Act, or
5 Marchman Act cases. We'll have trauma related
6 services.

7 And instead of just kicking people to the
8 curb once we have adjudicated their case we
9 will slowly, gently, reintegrate them back into
10 society with all the supports and services and
11 long-term management to manage their illness.
12 We don't have to fix the whole system. You can
13 target the system and make it work for the
14 people that need the different level of
15 illnesses. Thank you.

16 CHAIR: Okay, thank you, Judge Leifman.
17 We certainly appreciate you being here, and
18 your expertise. So, that concludes the
19 presentations in the open session for today.
20 We made up a lot of time here this afternoon.
21 I know I've had some discussions with some of
22 you about, you know, potential, what we're
23 going to do with the schedule the rest of the
24 day, but I think it's best that we just power
25 through this and, and continue with the closed

1 session, because we're not that far. We're
2 only probably about fifteen, twenty minutes off
3 schedule right now.

4 So, what we're going to do is hear the
5 public comment, and then we'll announce the
6 closed session, and then we'll begin with the
7 agenda items in the closed session. So, for
8 public comment, and again we will ask all those
9 who are speaking during the public comment
10 session section to limit your comments to three
11 minutes. And the first person that we'll hear
12 from is David Clemente.

13 PUBLIC COMMENTS

14 MR. CLEMENTE: Good afternoon, Chair and
15 commissioners. My name is David Cobra
16 Clemente. I am the Chapter Leader of Parkland
17 Guardian Angels. I came into Parkland on the
18 first day of the shooting. I been there ever
19 since. The beginning of this school year when
20 they started, start back up after this
21 shooting, I brought in a team of Guardian
22 Angels, which we've been at Douglas High School
23 ten to twelve hours per day five days a week.
24 We started our day off at 3:00 in the morning,
25 and we didn't leave until the end of that last

1 bell at 3:00 in the afternoon.

2 We have the okay of the City. We had the
3 okay of the commission, the okay of the mayor.
4 We set up a tent outside of Douglas High
5 School. We had hundreds and hundreds of
6 parents that came by, stopped by, and either
7 call or text the Guardian Angels and thank for
8 our support. We had students that would stop
9 by the tent to speak to the Guardian Angles.
10 Most of the students who had been affect with
11 the shootings stopped by and they talked to us
12 and told how us how their feelings was of the,
13 of the shootings. We had a whole lot of
14 students, while they was in school they would
15 call the Guardian Angles while we were sitting
16 outside in the tent and told us the situation
17 of what was going on inside the school.

18 We had hundreds of parents that would call
19 us and let us know, that the kids feel safe
20 when they see the Guardian Angels outside of
21 that school every single day of that school
22 year. Now, when the school year had ended we
23 figure we can't do this for another year,
24 because when we came in to Parkland, I am, I'm
25 from Florida, I live in Tamarac, so when we

1 came into Parkland the guys that I brought
2 there, my team that I brought there, we donated
3 all our time, so the team that I brought into
4 Parkland, they took four months out of work to
5 make sure they're at that school every single
6 day, and make sure those kids were safe, the
7 teachers were safe, that community was safe.

8 Now we've decided that we would pull out
9 of, pull out of the school so they get back to
10 form, fortunately we received while we was away
11 from Parkland hundreds and hundreds of calls
12 that went into our national headquarters, and
13 plus hundreds of calls that came into me, and
14 text messages to me, through Facebook, and
15 begging the Guardian Angels please do not leave
16 Parkland, and do not leave this Douglas High
17 School.

18 So, what the Guardian Angels decided to
19 do, we're going to put together an Angel Watch
20 Program for all five schools that's in
21 Parkland, not inside the schools but the
22 perimeter of the schools, on the outside of the
23 schools. We are only the eyes and the ears of
24 the police department, we only the eyes and
25 ears of the community. What we see we say. We

1 see something, you say something. That's what
2 we there to do.

3 We have -- we have the love, like I said,
4 of Parkland, and plus the City of Parkland. We
5 received awards from the commission, we
6 received the highest award from Douglas,
7 Douglas Stoneman High School, sorry, and we
8 received awards from the mayor department, we
9 received hundreds of letters that came in from
10 the city. We received gift cards, and we
11 received cards, you know, regular cards from
12 the students. This is all from Parkland, but I
13 what I would like, what I would like to do, and
14 hope to see, is that's just Parkland, I would
15 love for some of the commissioners that's here
16 also to give the support to the Guardian Angels
17 why we there. So, this is what I wanted to
18 say.

19 CHAIR: Okay, thank you, sir, we
20 appreciate your comments.

21 MR. CLEMENTE: Thank you, sir. Thank you,
22 guys. Thank you.

23 CHAIR: Next citizen comment is Jeff
24 Ostroff.

25 MR. OSTROFF: Hi, good afternoon,

1 commissioners. I just wanted to touch base on
2 the topic I brought up yesterday about the, you
3 know, the repeaters. You know, it's great that
4 we're moving on this new system, the new radio
5 system, and that I think eliminates one of the
6 big weak links in our system here. But then
7 when you remove the big links now you want to
8 start looking at some of the smaller ones, and
9 one of the ones that I had figured causes a
10 problem for us is what if all of the sudden you
11 got this new system, and now you're racing to
12 the scene of active shooting, and you run into
13 the building and now you have no signal. That
14 just kind of undoes everything you worked for
15 so hard.

16 So, what I had suggested yesterday, and
17 what I wanted to expand on a little bit, was
18 putting, you know, repeaters inside the schools
19 for your public services frequencies. And to
20 do that you don't just put a, you know, a
21 repeater up on the wall, you have to, and call
22 it day, and say it's beer thirty, let's go
23 home. You'd really need to go around and
24 characterize the entire campus, and you need to
25 find out where you have voids in the signal.

1 You got to check all your classrooms, the
2 hallways, the staircases. You've got to check
3 the cafeteria, the administration offices, and
4 you got to make sure that there aren't any
5 voids in coverage anywhere. You don't want to
6 run into a building anywhere and find out that
7 your radio didn't work, because if you thought
8 public outcry was bad on this case just wait
9 until it happens again, and the public is
10 really mad. You don't want to be on the end of
11 that barrel for sure.

12 And then one of the other logistical ideas
13 I was thinking about is, you know, now with the
14 new Senate bill, the 7026, and there's more
15 security in the schools now, you know, you
16 might find a lot of schools have single point
17 entry now, and all the doors are going to be
18 locked, but if you have a hundred fifty cops
19 racing to the scene of an active shooting
20 system how are you going to get in the door,
21 who has the key? Has that all been worked out,
22 you know, is there like a lock box on the
23 outside of the building with master keys that
24 you can hand out real quickly, because you
25 won't have time to run to the office to find

1 the security guys, or whoever might have the
2 key. They might hide in the, in the custodial
3 closet, as we saw at MSD.

4 So, those are some things that I think you
5 should all consider and work out. Thanks.

6 CHAIR: All right, thank you. Michael
7 Sirbola.

8 MR. SIRBOLA: Hello. As we said earlier,
9 trauma is biological. This is really
10 important. Culture is biology. We are humans,
11 not animals. We are tool users. Humans do not
12 literally gnaw on themselves, as will an animal
13 stressed beyond its ability to cope. No, what
14 we do is we use tools, not teeth, we cut. Our
15 children are literally gnawing on themselves.
16 What are we going to do about it?

17 Your punitive versus empathy-based system
18 prevents people from calling the place, DCF, or
19 school counselors. They're afraid. They wait
20 until they're almost dying before they make the
21 call, in the case of the hospitals. We aren't
22 trustable to deliver help instead of
23 condemnation and judgment, and we tend to make
24 things worse in many occasions, at least in the
25 eye of the public. This needs to change.

1 Right now, you know, speaking of making
2 things worse, we're about to put in a person
3 with a gun in every one of our schools.
4 There's a shortage of those so we're going to
5 have eighty guardians. We just heard some
6 truly terrifying statistics on police and
7 military mental health. I'm going to ask that
8 you as a committee, following just as the FDA
9 does when it's investigating drugs, if it finds
10 great efficacy it steps in and changes the
11 course of that, and puts it out and makes it
12 available to everyone. I'm going to ask that
13 you as a committee perhaps meet in private and
14 come to the conclusion that those eight
15 officers, or two hundred fifty, get trauma
16 aware training so that they can calm
17 themselves, and so they can know how to deal
18 with these children.

19 It's very specific training. Dr. Ablon
20 with Think:Kids.org trained all five thousand
21 plus officers up in New York and saw more than
22 a fifty percent reduction in antagonistic
23 interdictions. And then there's also Dr.
24 Gordon with the Mind Body Medicine Institute
25 that will help them to learn how to calm

1 themselves in, in difficult situations, and
2 deal with their own trauma. I'm talking about
3 the officers. Please, this is an emergency
4 request. As a commission it's something that
5 isn't on your current agenda, but I ask that
6 you consider to do because we need to get this
7 training done before they come in here.

8 Under funding is child abuse. This isn't
9 happening by accident. Our kids aren't the
10 issue, we are. We implemented zero tolerance,
11 and disrespected our own children, and created
12 an us and them situation, and we're dealing
13 with their response to our actions. How many
14 of you I wonder are aware of the billion-dollar
15 complex PTSD lawsuit in Compton, California?
16 It was filed by a number of teachers, actually
17 six. There were six teachers and students who
18 got together, they sued the school district in
19 a billion-dollar lawsuit.

20 If you're not familiar with what complex
21 PTSD is it's what we do to our children every
22 day in our society in schools where they're
23 basically pinpricked just a little bit, and
24 they have no control over that, and over time
25 that affects who they are, how they behave. In

1 other words, this doesn't, this changes how we
2 react to things. We think more in terms of
3 black and white, we're more reactive --

4 CHAIR: Okay, thank you, Mr. Sirbola.

5 MR. SIRBOLA: -- and then it affects our
6 organizations, all of them, all of them,
7 because --

8 CHAIR: Your time -- your time is up.
9 Thank you.

10 MR. SIRBOLA: -- it's behaviorally
11 transmitted. Thank you.

12 CHAIR: As we transition now into the
13 closed session, in order to do that I've got to
14 read the following. This meeting requires us
15 to here and discuss active criminal
16 investigative information, active criminal
17 intelligence information, and/or other
18 information that is confidential and exempt
19 under Florida law. Because of this under the
20 authority of Florida Statute 943.687(8) the
21 meeting is closed to the public and is exempt
22 from Florida's Sunshine Law found at Florida
23 Statute 286.011 and Section 24(b) Article I of
24 the State Constitution.

25 The required written declamation of the

1 commission chair will be entered into the
2 commission minutes. Only authorized commission
3 members, commission support staff, and persons
4 otherwise specifically authorized by the Chair
5 may attend this meeting. We will not reconvene
6 today in a public meeting. We will take a
7 brief break and begin the closed portion of the
8 meeting in about five minutes. Thank you for
9 your consideration.

10 So, we'll take a five-minute break, and
11 we'll come back in closed session.

12 (Thereupon, the above meeting concluded for the
13 day.)

C E R T I F I C A T E

(STATE OF FLORIDA)

(COUNTY OF BROWARD)

I, NIDELIS GONZALEZ, Reporter, certify
that I was authorized to and did report the
foregoing proceedings and that the transcript is a
true and correct transcription of my notes of the
proceedings.



NIDELIS GONZALEZ, Reporter

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Expires: 01/11/2019

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