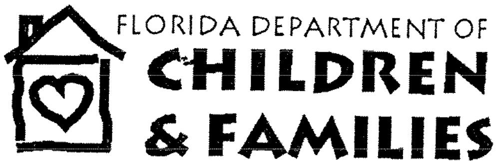


Jeb Bush
Governor

Kathleen A. Kearney
Secretary

DATE: November 20, 2000

TO: Kathleen A. Kearney
Secretary

FROM: Guiseppe A. Betta
Inspector General

SUBJECT: Inspector General Response to OPPAGA Recommendations Regarding Incident at Martin Treatment Center for Sexually Violent Predators

For your information, attached is the Office of Inspector General response to recommendations contained within the OPPAGA Special Review: Effectiveness and Monitoring of Martin Treatment Center for Sexually Violent Predators report.

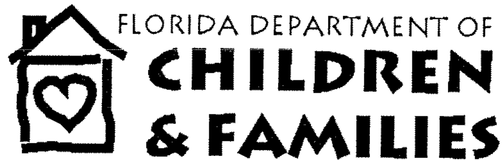
As you will notice, my office did not deem it appropriate to conduct a full investigation of allegations within the report regarding an after-hours party that involved inappropriate behaviors on behalf of Martin Center staff in October 1999, as recommended by the OPPAGA. Without question, the alleged incident occurred. Therefore, an investigation would have served no useful purpose.

However, we are of the opinion that the Department should assure that appropriate corrective measures were taken, and that the provider agency realizes that a similar incident cannot occur again. Based upon our review of the corrective action plan the Mental Health Program Office is tracking, we feel appropriate corrective measures are occurring. Therefore, our review of this matter is concluded. However, we will be tracking the status of the corrective action plan until all steps are completed.

If you have questions or comments, please feel free to contact me at 488-1225.

Cc:
Robert Williams
Assistant Secretary for Programs

Celeste Putnam
Program Director
Mental Health Program Office



Office of Inspector General

Response to Allegations Involving Inappropriate Behavior on Behalf of Staff at The Martin Treatment Center for Sexually Violent Predators

Background:

On September 20, the Office of Inspector General received a telephone call from Marti Harkness of the Office of Program Policy Analysis and Government Accountability (OPPAGA) regarding allegations of inappropriate behavior by staff at the Martin Treatment Center for Sexually Violent Predators. According to Mr. Harkness, his agency identified the alleged inappropriate behavior during a special legislative review, and the matter was to be addressed within a forthcoming OPPAGA summary report entitled Special Review: Effectiveness and Monitoring of Martin Treatment Center for Sexually Violent Predators. Because the OPPAGA summary contained discussions about the alleged inappropriate behavior, a recommendation was being made to the Department that the Inspector General should conduct a thorough investigation to determine if the alleged incident took place and make recommendations regarding appropriate action. The Inspector General advised Mr. Harkness the allegations would be reviewed and appropriate action would be taken.

Before discussing actions taken on behalf of this office, it should be noted that the Department contracts with Liberty Behavioral Healthcare, Inc., (LBH) to operate the Martin Treatment Center. The Center is located in Stuart, Florida, and is funded by the Florida Legislature via the Civil Commitment of Sexually Violent Predators Act (Jimmy Ryce Act). The intent of the program is to treat persons who have been convicted of sexually violent offenses and have mental abnormalities or personality disorders that, left untreated, will likely result in episodes of sexually violent behavior.

Summary of Inspector General Involvement:

To briefly summarize the alleged incident, on October 26, 1999, a going away party was held at a privately owned restaurant to honor the departing clinical director. Allegedly, staff engaged in inappropriate behaviors of a sexual nature during the party. Also, it was alleged that staff were told to attend the party, and that several staff members became intoxicated. During the "roast" portion of the party, the parting clinical director was given a gift bag containing sex toys and other "pornographic" items. The director proceeded to touch staff inappropriately with one of the toys, and he made several sexually explicit gestures. Other management staff were alleged to have participated in the sexually suggestive behavior, until one employee threatened to file a sexual harassment suit. Once the threat was made, the activity ceased. According to the

anonymous complainant, senior managers did not take appropriate steps to halt the behavior, and several staff were made to feel uncomfortable because of the incident.

On September 26 and 27, 2000, the Office of Inspector General initiated a preliminary inquiry via telephone interviews with staff of the Mental Health Program Office (Greg Venz) and the Office of Civil Rights (Carolyn Dudley). During these conversations, it was learned that:

- Without question, the alleged incident occurred in October 1999, at an off-site, after-hours going away party for the retiring director.
- After learning of the incident in November 1999, Greg Venz, Director of the Sexually Violent Predators Program, who is also the contract manager, verbally admonished the Chief Executive Officer of LBH. The Chief Executive Officer was advised that incidents that even hint at sexually suggestive behaviors toward staff could not occur again, and that a repeat incident would not be tolerated. According to Mr. Venz, the Chief Executive Officer agreed that the behaviors were inappropriate and that a similar incident would not occur again. To date, there have been no recurrences.
- State and federal laws were not violated because the alleged behaviors did not occur at the work-site, and LBH stated that participation at the function was not mandatory.
- The events that occurred at the October 26, 1999, going away party were, without question, sexually suggestive and were of such a nature that they could have carried over into the work environment, thereby creating a sexually hostile work environment.
- It was agreed that the behavior at the party was in poor taste, and that such actions on behalf of management staff who work in a program that treats sexual predators was highly insensitive. Also, such behaviors could easily give the perception that sexually offensive behavior is not viewed seriously by the Treatment Center.
- The Department needs to assure that the provider understands the seriousness of the allegations, and that a repeat incident will not be tolerated.

On September 29, 2000, a meeting was held to discuss the Inspector General's response to the Martin Treatment Center allegations. Participants included representatives from the Office of Civil Rights, Mental Health Program Office Sexually Violent Predator Program, and the Office of Inspector General. Consensus was reached that an Inspector General investigation was not in order because it was well established that the alleged incident had occurred. However, because corporate staff were in attendance and participated in some of the offensive behaviors, it was also agreed that LBH should be required to demonstrate corrective measures to assure that similar incidents do not occur again. The Office of Civil Rights recommended that corporate and center employees participate in sexual harassment training and, if needed, the Office of Civil Rights would be available to provide the training.

The Inspector General was of the opinion that the contract manager should prepare a letter to the Chief Executive Officer of LBH to inform the agency of the following:

- that the Department was dissatisfied with the events that occurred at the October 26, 1999, going away party;
- that LBH should submit a corrective action plan by a specified date;

- that the corrective action plan is to assure the Department that staff at the Martin Treatment Center understand that a similar incident cannot happen again; and,
- that LBH must assure the Department that appropriate disciplinary action was taken.

A draft letter was prepared by the Director of the Sexually Violent Predator Program (Greg Venz), staffed with the Inspector General, and forwarded to the provider on October 19, 2000. On November 17, 2000, after contacting LBH, Mr. Venz received a response to the request for corrective measures, and his office provided the Inspector General with a copy.

Upon review of the response, we have determined that LBH has taken the following steps to ensure that incidents similar to the ones described above do not occur again:

- all staff present at the incident have been interviewed and counseled regarding the inappropriateness of the behavior demonstrated on October 26, 1999;
- all LBH staff are receiving sexual harassment training;
- all LBH staff received an employee manual which includes LBH policies regarding sexual harassment; and,
- LBH has discontinued its purchase of service agreement with the subcontractor who was considered to be the initiator of the inappropriate behavior.

The Director of the Sexually Violent Predator Program will monitor the provider's corrective action plan and assure that all corrective measures are completed. It is my understanding that failure to adhere to the corrective action plan will result in termination of the contract with LBH.

Conclusions:

Because the Mental Health Program had already determined the allegations were true, and had addressed the issue to at least some degree several months prior to this report, the OPPAGA recommendation that the Inspector General should conduct a thorough investigation to determine if the alleged incident took place was not pursued as it would serve no useful purpose. Without question, the incident occurred. Instead, the Inspector General was of the opinion that the appropriate action was to assure that the provider (LBH) understands the seriousness of the inappropriate behaviors, and that the provider clearly understands that similar incidents cannot occur again. Based upon our review of the LBH corrective action plan and the willingness of the Sexually Violent Predator Program Director to monitor and track the plan, the matter is being addressed appropriately.

At this point, it appears the best response is to assure that those who were involved in the incident have been dealt with appropriately, and that the Mental Health Program Office monitors corrective measures to be sure that similar incidents do not occur again. Most importantly, all persons familiar with these events must clearly understand that the Department will not tolerate, under any circumstances, incidents of this nature by anyone working in, or contracting with, the Department.