INVESTIGATION OF THE LOWELL CORRECTIONAL INSTITUTION – FLORIDA DEPARTMENT OF CORRECTIONS (OCALA, FLORIDA)

United States Department of Justice
Civil Rights Division

United States Attorney's Office
Middle District of Florida

December 22, 2020

TABLE OF CONTENTS

I. SUMMARY 1
II. INVESTIGATION 2
III. THE LOWELL CORRECTIONAL INSTITUTION AND FDOC 3
IV. CONDITIONS IDENTIFIED 4
A. Staff Sexual Abuse of Lowell Prisoners Violates Prisoners' Constitutional Rights. 4
B. Inadequate Systems for Preventing, Detecting, and Responding to Sexual Abuse Place Lowell Prisoners at Substantial Risk of Serious Harm from Staff Sexual Abuse. 13
C. Officials at Lowell Knew of the Risk to Prisoners from Staff Sexual Abuse and Disregarded It. 30
V. MINIMAL REMEDIAL MEASURES 33
VI. CONCLUSION 34

I. SUMMARY

The Department of Justice's Civil Rights Division and the U.S. Attorney's Office for the Middle District of Florida (the Department) provide notice, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §§ 1997 *et seq.* (CRIPA), that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered that: (1) conditions at the Lowell Correctional Institution (Lowell) violate the Eighth Amendment of the United States Constitution due to the sexual abuse of prisoners by the facility's staff; and (2) these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment. The Department does not serve as a tribunal authorized to make factual findings and legal conclusions binding on, or admissible in, any court, and nothing in this Notice of Investigative Conclusions (Notice) should be construed as such. Accordingly, this Notice is not intended to be admissible evidence and does not create any legal rights or obligations.

Specifically, the United States provides notice that the State of Florida, through the Florida Department of Corrections (FDOC), fails to keep prisoners at Lowell safe from sexual abuse by staff. FDOC has documented and been aware of a pattern or practice of staff sexual abuse of Lowell prisoners since at least 2006. Despite being on notice of this sexual abuse, FDOC and Lowell failed to take timely action to remedy the systemic problems that have enabled corrections officers and other staff to continue to sexually abuse Lowell prisoners.

As documented in this Notice, Lowell prisoners have suffered harm from sexual abuse and are at substantial risk of serious harm because existing systems discourage prisoners from reporting sexual abuse and fail to effectively detect and deter sexual abuse. Between 2017 and the present, Lowell sergeants, corrections officers, and other staff have committed notorious acts of sexual abuse, including rape, against prisoners. For example, in July 2020, a sergeant was arrested and charged with sexual misconduct after he admitted to engaging in oral sex with a prisoner in the maintenance room of a prisoner dormitory as recently as April 2020. That same sergeant had been accused in 2017 of sexually abusing a different prisoner, causing lesions on the prisoner's throat from oral sex, and then retaliating against the prisoner when she refused his sexual advances. Even though FDOC verified the prisoner's injuries, FDOC never completed the investigation for the 2017 incident, and the officer remained employed until his arrest in July 2020.

This recent staff arrest is not an isolated incident. The Department identified evidence that Lowell has a long-standing pattern of criminal charges, discipline, and documented allegations of staff sexual abuse. In 2018, another sergeant allegedly raped a prisoner in a storage area, "pull[ing] [her] pants down and forc[ing] his penis in anally." Extensive photographic evidence documented the prisoner's injuries. Another officer allegedly took a prisoner to an outdoor area between two buildings, pushed her down, and forced his penis into her mouth. Prisoners repeatedly told the Department of officers making harassing, sexually explicit comments to them. One prisoner alleged in 2018 that an officer boasted to her that he had a large penis, and made graphic comments suggesting he wanted to perform oral sex on a Black woman. It is common for officers to grope prisoners, including their buttocks and breasts; bribe prisoners with contraband including drugs, cigarettes, food, and makeup in exchange for

sex; comment on prisoners' bodies using crude sexual language and names; compel prisoners into ongoing abusive sexual "relationships;" watch prisoners as they use the toilet or shower, and when changing clothes, without justification; and threaten prisoners with solitary confinement if they report sexual abuse.

Consistent with the statutory requirements of CRIPA, the Department writes this Notice to notify the State of Florida of our conclusions with respect to these constitutional violations, the facts supporting those conclusions, and the minimum remedial measures necessary to address the identified deficiencies.

II. INVESTIGATION

On April 17, 2018, the Department notified the State of Florida of our intent to conduct an investigation of Lowell pursuant to CRIPA. Our investigation focused on whether there is reasonable cause to believe that Lowell violates the constitutional rights of women prisoners by failing to take measures to reasonably protect them from the harm of staff sexual abuse during their incarceration at Lowell.

On July 9, 2018, August 15, 2018, and November 19, 2018, the Department issued subpoenas for documents and information to relevant State and facility officials. In August 2018 and November 2019, representatives from the Department conducted four-day, on-site reviews of Lowell. An expert consultant in correctional operations and sexual safety of incarcerated persons assisted with our investigation and participated in the on-site reviews. Our expert is a former warden of a women's prison with 35 years of experience working with corrections and other criminal-justice related organizations. Over the course of our visits, the Department interviewed FDOC and Lowell administrative staff, security staff, medical and mental health staff, and prisoners. In preparation for and during our on-site reviews, we reviewed documentation produced by Lowell and FDOC. Over the course of on-site reviews, we toured the Lowell campus at different time intervals. We observed and met with prisoners in various settings throughout the facility, including all security levels, vocational programs, and restrictive housing units. We conducted an exit conference with Lowell and FDOC officials upon the conclusion of our August 2018 visit in order to provide transparency and technical assistance during the course of the investigation. FDOC officials, the Lowell administration and staff, and their legal representatives cooperated with and facilitated our on-site reviews.

Following our on-site reviews, we requested, and the State produced, additional documentation relevant to our investigation. Throughout the course of our investigation, the State produced over 108,505 pages of documents. The Department and its expert conducted extensive document review of policies and procedures, staffing information, prisoner files, incident reports, investigative reports, disciplinary reports, administrative audit reports, prisoner grievances, unit logs, orientation materials, training materials, and quality assurance materials. FDOC's Office of the Inspector General (OIG) also cooperated with the Department by providing additional clarifying information and documentation throughout the course of the investigation. The State also provided updated information as to its efforts to address issues related to sexual abuse.

III. THE LOWELL CORRECTIONAL INSTITUTION AND FDOC

Lowell is located in Ocala, Florida, about an hour and a half north of Orlando. It is the oldest women's prison in Florida, having opened in 1956, and is the largest women's prison in the country. Lowell sits on approximately 315 acres of land. The Lowell campus is comprised of the Lowell Correctional Institution (Main Unit), the Lowell Annex, and the Lowell Work Camp.[1] On November 19, 2019, the population of the Main Unit was 893 and the population of the Annex was 1,371, for a total of 2,264 in the two facilities. The population includes adult women and youthful inmates.[2] It also houses pregnant prisoners, prisoners who use wheelchairs, deaf prisoners, and prisoners with other disabilities. The facility holds all custody levels to include community, minimum, medium, close,[3] and maximum. The number of staff in the entire Lowell campus who have contact with prisoners is 595.

The physical plant of Lowell consists of 74 buildings, of which 27 are designated for prisoner housing. The Lowell Main Unit has 14 housing units; 12 are open-bay dormitories and two are celled housing. The Lowell Main Unit also has one chapel, ten classrooms, two dining halls and one visitation park. The Lowell Annex has eight housing units; five are open-bay dorms and three are celled housing, with one of the three having six death row cells that are single celled. The Lowell Annex houses general population, close management, and prisoners in segregation, as well as death row. There are a total of 168 cells designated for administrative and disciplinary confinement on the Lowell campus.

FDOC is the third-largest state prison system in the country with an annual budget of $2.4 billion. It is the largest state agency in Florida. FDOC houses approximately 96,000 prisoners in its 145 correctional facilities statewide. Of these, approximately 6,600 are women in 14 facilities. FDOC Secretary Mark S. Inch took office in January 2019, becoming the seventh Secretary since 2006. FDOC includes the OIG, which is responsible for investigating criminal and administrative violations, as well as audits to detect fraud, waste, and abuse.[4] The operationally independent OIG falls under the administrative umbrella of FDOC and is funded by FDOC.

---

[1] The Lowell Work Camp, which was not part of our investigation, sits on 14 acres.

[2] The term "youthful inmate" refers to "any person under the age of 18 who is under adult court supervision and incarcerated or detained in a prison or jail." *See* 28 C.F.R. § 115.5. FDOC's "youthful offender" programs include inmates under 18 and up to age 24. *See* Florida Department of Corrections Annual Report 2018-19 at 23, http://www.dc.state.fl.us/pub/annual/1819/FDC_AR2018-19.pdf.

[3] "Close management" is defined as "the confinement of an inmate apart from the general population, for reasons of security or the order and effective management of the institution, where the inmate, through his or her behavior, has demonstrated an inability to live in the general population without abusing the rights and privileges of others." Fla. Admin. Code R. § 33-601.800(d).

[4] In late June 2020, Inspector General Lester Fernandez resigned, reportedly under pressure from FDOC leadership after voicing concerns about FDOC's support of OIG's investigative mandate. *See* http://dc.state.fl.us/ig/index.html; *see also* Samantha J. Gross, *Florida Prisons, Among Nation's Deadliest, Didn't Like "Demanding" Watchdog. He's Gone*, Miami Herald, Oct. 1, 2020, https://www.miamiherald.com/news/special-reports/florida-prisons/article245495495.html.

IV. CONDITIONS IDENTIFIED

FDOC and Lowell are violating the Constitution by failing to protect prisoners from serious harm and a substantial risk of serious harm. *See Farmer v. Brennan*, 511 U.S. 825, 833 (1994); *Helling v. McKinney*, 509 U.S. 25, 31-35 (1993). The Department's investigation has uncovered facts that provide reasonable cause to conclude that Lowell (1) fails to protect women prisoners from sexual abuse by staff in violation of the Eighth Amendment; and (2) exposes women prisoners to substantial risk of serious harm from sexual abuse in violation of the Eighth Amendment. Systemic failures in Lowell's policies and practices discourage reporting of sexual abuse; lead to an inadequate response to, and investigation of, allegations of sexual abuse; and result in grossly inadequate supervision that provides opportunities for further sexual abuse.

As detailed below, the combination of numerous, specific, and repeated violations of the Eighth Amendment at Lowell, taken together with multiple deficient policies and practices that caused or contributed to those violations, establishes a pattern or practice of constitutional violations. CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of prisoners whose rights are violated subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. To establish a pattern or practice of violations, the United States must establish by a preponderance of the evidence that violating federal law was "standard operating procedure—the regular rather than the unusual practice." *Hipp v. Liberty Nat'l Life Ins. Co.*, 252 F.3d 1208, 1227 (11th Cir. 2001) (quoting *Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 336 (1977)). In some sections we provide more examples to illustrate the variety of circumstances in which the violations occur, while in others we focus on one or two examples that demonstrate the nature of the violations we found. The number of examples included in a particular section is not indicative of the number of violations we found. These examples comprise a small subset of the total number of incidents upon which we base our conclusions.

A. Staff Sexual Abuse of Lowell Prisoners Violates Prisoners' Constitutional Rights.

1. *Failure to Protect Prisoners from Harm from Sexual Abuse Violates the Eighth Amendment.*

The Eighth Amendment governs "the treatment a prisoner receives in prison and the conditions under which [s]he is confined." *Helling*, 509 U.S. at 31. Prisons are required under the Eighth Amendment to protect prisoners from a range of types of harm and to take reasonable measures to protect prisoners' safety. *Farmer*, 511 U.S. at 832 (citing *Hudson v. Palmer*, 468 U.S. 517, 526-527 (1984)). The "unnecessary and wanton infliction of pain" constitutes cruel and unusual punishment forbidden by the Eighth Amendment. *Farrow v. West*, 320 F.3d 1235, 1243 (11th Cir. 2003) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). The Eighth Amendment protects prisoners from sexual abuse, even when there is no serious physical injury. *Sconiers v. Lockhart*, 946 F.3d 1256, 1267 (11th Cir. 2020) (holding that an Eighth Amendment claim of sexual assault where a corrections officer digitally penetrated a prisoner's anus through his pants did not fail as a matter of law, and such a claim was not barred even if any resulting injuries were *de minimis*). Sexual misconduct by corrections officers and other prison staff can

violate the Eighth Amendment, regardless of whether physical force is used. *See id.* ("The lack of serious physical injury, considered in a vacuum, cannot snuff out Eighth Amendment sexual-assault claims."); *Crawford v. Cuomo*, 796 F.3d 252, 257 (2d Cir. 2015) ("To show that an incident or series of incidents was serious enough to implicate the Constitution, an inmate need not allege that there was penetration, physical injury, or direct contact with uncovered genitalia.").

Prison conditions violate the Eighth Amendment's prohibition against cruel and unusual punishment if they are caused by deliberate indifference to a substantial risk of serious harm to prisoners. *Farmer*, 511 U.S. at 828. To establish a prison official's deliberate indifference, a complainant must meet both objective and subjective requirements of this standard. *See id.* at 834. Specifically, the claimant must show: (1) facts presenting an objectively substantial risk to prisoners and awareness of these facts on the part of the officials charged with deliberate indifference; (2) that the officials drew the subjective inference from known facts that a substantial risk of serious harm existed; and (3) that the officials responded in an objectively unreasonable manner. *Doe v. Georgia Dept. of Corrs.*, 248 F. App'x 67, 70 (11th Cir. 2007).

The subjective component requires that the prison official "acted with a sufficiently culpable state of mind," while an objective component requires that "the alleged wrongdoing was objectively harmful enough to establish a constitutional violation." *Hudson v. McMillian*, 503 U.S. 1, 8 (1992). The prison officials need not be complicit in the harmful acts, nor have specific knowledge that a particular prisoner is suffering abuse; "it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Farmer*, 511 U.S. at 839, 842. Prison officials who are aware of a substantial risk to prisoner safety must respond reasonably to the risk in order to ensure "reasonable safety." *Id.* at 844 (noting that prison officials may avoid liability "if they responded reasonably to the risk, even if the harm ultimately was not averted."). "Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence." *Id.* at 842.

A prisoner has a right, secured by the Eighth Amendment, to be reasonably protected from sexual abuse. *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1379 (M.D. Ga. 2015) (quoting *Purcell ex rel. Estate of Morgan v. Toombs Cnty.*, Ga., 400 F.3d 1313, 1320 (11th Cir. 2005)) (internal quotation marks and citation omitted). "Some things are never acceptable, no matter the circumstances. Sexual abuse is one." *Sconiers*, 946 F.3d at 1259. Sexual abuse of a prisoner by a corrections officer has "no legitimate penological purpose"; if the purpose of an official's action is to gratify himself or to "sadistically and maliciously . . . caus[e] harm," then sexually assaultive behavior constitutes an Eighth Amendment violation. *Id.* at 1266 (quoting *Crawford*, 796 F.3d at 259-60); *Johnson v. Breeden*, 280 F.3d 1308, 1321 (11th Cir. 2002)). In an Eighth Amendment analysis, an officer's intent to harm can be inferred, not only from behavior that is injurious or "malicious," but also from behavior whose purpose is to sexually gratify the officer or to humiliate the victim. *See, e.g.*, *Crawford*, 796 F.3d at 257 ("A corrections officer's intentional contact with an inmate's genitalia or other intimate area, which serves no penological purpose and is undertaken *with the intent to gratify the officer's sexual desire* or to humiliate the inmate, violates the Eighth Amendment.") (emphasis added); *Ricks v. Shover*, 891 F.3d 468, 476 (3d Cir. 2018) ("Absent a legitimate penological purpose, the type of touching involved in, for

instance, a body-cavity search, would be undoubtedly cruel and unusual. And a desire to humiliate the inmate *or gratify the officer*—inferred through the officer's conduct—is a reasonable way to distinguish between invasive touching that is permitted by law to ensure safety and that which is not.") (emphasis added); *Washington v. Hively*, 695 F.3d 641, 643 (7th Cir. 2012) (holding that sexual contact "intended to humiliate the victim *or gratify the assailant's sexual desires*, can violate a prisoner's constitutional rights whether or not the force exerted by the assailant is significant") (emphasis added); *Ullery v. Bradley*, 949 F.3d 1282, 1295-98 (10th Cir. 2020) (collecting cases); *see also Sconiers*, 946 F.3d at 1270 (Rosenbaum, J., concurring) ("By 'sexual abuse,' I mean coerced sexual contact that is engaged in by a correctional official to humiliate a prisoner, to maliciously and sadistically harm a prisoner, *or to sexually gratify a correctional official* (or some combination of these reasons).") (emphasis added).

Sexual abuse through coercion, threats, preferential treatment, or disciplinary action also can constitute abuse in violation of the Eighth Amendment. *See, e.g.*, *Ricks*, 891 F.3d at 478 (noting that "objectively serious sexual contact" sufficient to establish an Eighth Amendment claim "would include sexualized fondling, coerced sexual activity, combinations of ongoing harassment and abuse, and exchanges of sexual activity for special treatment or to avoid discipline"); *Brown v. Riley*, No. 08-cv-804, 2010 WL 3069490, at *4-5 (M.D. Fla. Aug. 4, 2010); *Walker v. Freeman*, No. 07-cv-3155, 2009 WL 63051, at *2 (N.D. Ga. Jan. 9, 2009) (holding that a prisoner stated a claim under the Eighth Amendment when a sheriff failed to remove a deputy despite knowing that the deputy used threats to force the prisoner to perform and submit to sexual acts).

Deliberate indifference may be established where a jurisdiction fails to protect prisoners from "obvious and known risks" including sexual harassment, physical assault, and coerced intimate relationships at the hands of corrections officers. *See J.K.J. v. Polk Cnty.*, 960 F.3d 367, 378-79 (7th Cir. 2020) (upholding a jury verdict finding deliberate indifference where municipality's policies and practices failed to prevent and detect sexual abuse); *see also Cash v. County of Erie*, 654 F.3d 324, 337 (2d Cir. 2011) (upholding a *Monell* jury verdict because "knowledge that an established practice has proved insufficient to deter lesser [sexual] misconduct can be found to serve [as] notice that the practice is also insufficient to deter more egregious misconduct").

In 2003, Congress enacted the Prison Rape Elimination Act (PREA) to combat sexual abuse in correctional settings. 34 U.S.C. § 30301, *et seq*. In 2012, the Attorney General published the National Standards to Prevent, Detect, and Respond to Prison Rape (PREA standards). 28 C.F.R. part 115, *et seq*. The PREA standards require zero tolerance for sexual abuse and sexual harassment of prisoners and detail a series of policy and practice reforms aimed at reducing correctional sexual abuse and sexual harassment and ensuring an adequate response to allegations of sexual abuse or sexual harassment. Although non-compliance with a PREA standard, alone, is not sufficient to support a finding of a constitutional violation, the PREA standards provide notice to jurisdictions of their obligations to protect prisoners from sexual abuse and sexual harassment.[5] Knowledge of, and failure to comply with, the PREA standards

---

[5] *See* Prison Rape Elimination Act of 2003, 34 U.S.C. § 30301(13) (2003) ("The high incidents of sexual assault within prisons involves actual and potential violations of the United States Constitution[;] States that do not

can serve as further evidence of subjective recklessness with regard to prisoner safety. *See, e.g.*, *Crawford*, 796 F.3d at 260 (finding PREA and state legislative enactments to be reliable evidence of contemporary standards of decency and, thus, relevant in evaluating whether specific acts of sexual abuse or sexual harassment give rise to an Eighth Amendment claim); *see also Farmer*, 511 U.S. at 839-40 (adopting "subjective recklessness" as the test for deliberate indifference under the Eighth Amendment).

"Contemporary standards of decency must be brought to bear in determining whether a punishment is cruel and unusual." *Bass v. Perrin*, 170 F.3d 1312, 1316 (11th Cir. 1999); *see also Estelle*, 429 U.S. at 102. State laws criminalizing sexual abuse by prison staff are important indicia that such acts violate contemporary standards of decency. *See Penry v. Lynaugh*, 492 U.S. 302, 331 (1989) ("The clearest and most reliable objective evidence of contemporary values in the legislation enacted by the country's legislatures"). At the state level, Florida criminalizes sexual relations between a corrections officer and a prisoner. Fla. Stat. §§ 794.011 (4)(b), (4)(e)(7) (making sexual battery by a corrections officer a first-degree felony); Fla. Stat. §§ 944.35 (3)(b)(1)-(2) (making sexual misconduct by a corrections officer a third-degree felony). Florida recognizes that, because of the imbalance of power between prison staff and prisoners, a prisoner cannot consent to sex with an officer; consent is not a defense. Fla. Stat. § 944.35 (3)(b)(3) ("The consent of the inmate . . . to any act of sexual misconduct may not be raised as a defense. . . ."); *see also* Fla. Stat. § 794.011 (e)(7) (criminalizing sex between a corrections officer and a prisoner where the prisoner may "reasonably believe that the offender is in a position of control or authority. . . .").

Nor do contemporary standards of decency permit a broad array of staff sexual misconduct, including non-penetrative sexual contact and sexual abuse of prisoners that does not result in any physical injury. Under PREA, rape includes not only penetration, but oral sodomy, sexual assault with an object, and sexual fondling. 34 U.S.C. § 30309(9).[6] Likewise, the Prison Litigation Reform Act permits prisoners to recover damages based on, among other things, emotional injury due to sexual abuse. *See Sconiers*, 946 F.3d at 1259 (noting that "Congress itself implicitly recognized" that sexual abuse of prisoners does not comport with contemporary standards of decency "when it amended the Prison Litigation Reform Act . . . to allow prisoners to recover damages 'for mental or emotional injury suffered while in custody[,] without a prior showing of physical injury,' when the prisoner can demonstrate 'the commission of a sexual act' as the basis for the damages he seeks") (quoting 42 U.S.C. § 1997e(e) (2013)).[7] In addition, the

---

take basic steps to abate prison rape by adopting standards that do not generate significant additional expenditures demonstrate [deliberate] indifference."); National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37189 (June 20, 2012) ("[T]he costs of full nationwide compliance [with the PREA standards] do not amount to substantial additional costs…").

[6] Moreover, under the National Standards promulgated pursuant to PREA, staff sexual abuse also includes staff voyeurism, staff exhibitionism, and mere "requests" by staff to engage in sexual contact. 28 C.F.R. § 115.6.

[7] Women prisoners are especially vulnerable to and likely to suffer harm from staff sexual abuse and sexual harassment because women prisoners are disproportionately likely to have previously experienced sexual abuse. Studies have confirmed high rates of previous victimization among women prisoners and that women with histories of sexual abuse are particularly traumatized by subsequent abuse. *See* National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37131-32 (June 20, 2012); *see also Jordan v. Gardner*, 986 F.2d

Fourth Amendment guarantees women prisoners' "constitutional right to bodily privacy" with regard to strip searches and unnecessary viewing of their unclothed bodies by male correctional staff "because most people have 'a special sense of privacy in their genitals, and involuntary exposure of them in the presence of people of the other sex may be especially demeaning and humiliating.'" *Fortner v. Thomas*, 983 F.2d 1024, 1030 (11th Cir. 1993) (quoting *Lee v. Downs*, 641 F.2d 1117, 1119 (4th Cir. 1981)).

2. *Lowell Prisoners Have Suffered Serious Harm from Staff Sexual Abuse and the Substantial Risk of Serious Harm.*

Sexual abuse of women prisoners by Lowell corrections officers and staff is severe and prevalent throughout the prison. In the course of our investigation, the Department and its expert reviewed 100% of the investigation files produced by FDOC of reports of sexual abuse and sexual harassment of Lowell prisoners over several years, including 161 investigations of staff-on-prisoner allegations from 2015 through 2019. Of the 161 sexual misconduct investigations and complaints our expert reviewed, eight were closed by arrest of the officer. In several cases, officers resigned in lieu of separation for cause or resigned while under investigation for sexual misconduct; more than two dozen more officers were dismissed due to "agency policy" or for committing felony or misdemeanor perjury or for making false statements.[8] Dozens more contained detailed, credible allegations of sexual abuse. In total, we identified a sufficient number of incidents of sexual abuse to provide compelling evidence in support of our conclusion that there is reasonable cause to believe there is a pattern and practice of sexual abuse at Lowell. This pattern and practice conclusion is bolstered by evidence of pervasive sexual harassment.

Incidents of staff sexual abuse of prisoners at Lowell are varied and disturbing. Some staff abused prisoners through unwanted and coerced sexual contact, including sexual penetration, and groping. Prisoners were forced or coerced to perform fellatio on or touch the intimate body parts of staff. In other instances, staff demanded that prisoners undress in front of them, sometimes in exchange for basic necessities, such as toilet paper. Many prisoners reported that staff watch them while they shower or use the toilet, with no penological justification. Lowell has a long history of tolerance for sexual abuse and harassment, which continues to the present. In interviews with the Department prisoners spoke of sex between staff and prisoners as a regular event, suggesting a normalization of sexual abuse by staff. Some current and former staff made similar representations.

The incidents of sexual abuse follow similar patterns where officers and staff sexually abuse women who are vulnerable to sexual victimization and fear retaliation, violence, deprivation of privileges, or endure sexual abuse in exchange for food, medication, or

---

1521, 1525 (9th Cir. 1993) (en banc) (finding that cross-gender pat searches of women prisoners violate their Eighth Amendment rights due to high likelihood that they will be traumatized by such searches in light of many women prisoners' histories of past sexual abuse).

[8] Between July 2015 and June 2018, fifteen Lowell officers were dismissed for violating agency policy and ten for committing a felony or misdemeanor involving perjury or a false statement. In these cases, FDOC has closed its investigation on the basis of a policy violation or false statement, rather than following through on the underlying allegations to determine their basis and accuracy, and whether sexual abuse was a predicate offense. These dismissals, thus, suggest that FDOC may knowingly be avoiding making findings of sexual abuse in some cases.

contraband, in violation of the prisoners' constitutional rights. Prisoners who report sexual abuse often are placed in confinement pending investigation, and it is common for staff to threaten prisoners who report abuse with retaliation, including placement in confinement. It is particularly disturbing that supervisors are among the repeat perpetrators of sexual abuse at Lowell. Not only does this misconduct set a poor example for line staff, but it also results in fewer checks and balances to detect and prevent abuse throughout the staff. In some cases, abuse allegations were channeled through alleged abusers, who were tasked with writing up incident reports on behalf of alleged victims.

Several Lowell officers and other staff have faced criminal charges based on allegations of sexual abuse of prisoners. For example:

- In July 2020, a corrections officer was arrested after he admitted to engaging in oral sex with a prisoner in a dormitory maintenance room at Lowell; the prisoner alleged that she and the officer also had sexual intercourse. The officer was charged with one count of sexual misconduct. This officer was credibly accused of sexual abuse previously, but had remained employed at Lowell and in close contact with prisoners. In February 2017, this officer allegedly handcuffed a prisoner, groped her vagina and breasts, placed her in confinement, and withheld hygiene products from her after she refused to go to the "usual place" to perform oral sex on the officer, as she had on multiple previous occasions over the previous two-and-a-half months. The prisoner also alleged that he had provided her with contraband including "nail polish, lip gloss and small pinches of snuff" in exchange for oral sex. A medical exam noted that the prisoner had two lesions on her throat, which she said resulted from performing oral sex on the officer. OIG opened an investigation into these allegations, but did not interview the officer and never completed the investigation. The officer remained employed at Lowell until he was arrested based on new allegations three years later.

- In September 2019, a trainee corrections officer was sentenced to two years in prison after he pleaded guilty to sexual misconduct with a prisoner, a felony under Florida law. The prisoner alleged that, on two separate occasions in September 2018, the officer, who was assigned to her housing unit, woke her up in the middle of the night along with prisoners who were being escorted to the pill line outside the dormitory. The officer then walked her to a bathroom, where she had sexual intercourse with him in exchange for suboxone, a prescription drug used to treat opioid withdrawal. The officer was dismissed for cause in September 2018.

- In February 2020, a former Lowell officer trainee turned himself in to the Marion County Sheriff's Office on charges of two counts of sexual misconduct with a prisoner. Forensic evidence from the prisoner identified the officer's DNA on the prisoner's shirt, which she reported was caused when he ejaculated during one of their sexual encounters. The prisoner reported that the officer demanded that she perform oral sex on him on two occasions in August 2018 and that she complied because she was "panicked" and "scared." According to an anonymous grievance, this prisoner also was helping the officer distribute contraband around the prison, and another prisoner allegedly also helped him distribute contraband; around the same time, she feared she was pregnant by

this officer. In September 2018, the officer was dismissed after contraband was found in his vehicle and he admitted to attempting to introduce contraband into the prison. OIG's investigation into allegations that this officer repeatedly coerced a prisoner to perform oral sex on him remained open for almost a year and a half following his dismissal; it was eventually closed in February 2020 due to the officer's arrest.

- A Lowell lieutenant was accused repeatedly of sexually abusing multiple prisoners at Lowell over several years, but remained in his position until 2019, when he was arrested for sexually molesting two minor girls in the community. FDOC did not respond adequately to previous allegations against this lieutenant, resulting in his remaining in close contact with and able to harm prisoners for several years. In 2019, another prisoner alleged that between March and April 2018 she had sexual intercourse with this lieutenant twice in a Lowell Annex dormitory in exchange for "favors" from him. This prisoner was transferred to another institution for her own safety. In 2018, another prisoner filed a third-party grievance accusing this lieutenant of receiving oral sex from another prisoner, and, after the report was made, calling the prisoner who made the report a "PREA bitch" and told her to "suck a dick." In 2017, the same lieutenant was accused of "sexually attack[ing]" another prisoner who alleged he groped her buttocks and "ma[de] comments that her butt is soft." This prisoner was transferred, but the lieutenant remained on duty, supervising prisoners at Lowell. At least two of these cases remained open as of November 2019 with no investigative findings on record.

  In addition to being a repeat sexual predator, this lieutenant also was credibly accused of unjustified use of force against a Lowell prisoner; in August 2019, he was accused of brutally beating a handcuffed Lowell prisoner and leaving her a quadriplegic. In August 2020, FDOC settled the lawsuit related to the prisoner's paralysis for $4.65 million. As part of that case, a former prisoner who recently had been released from Lowell testified under oath that this lieutenant threatened "to put you under investigation and take your gain time" if you did not "take care" of him, which the prisoner understood to mean "oral or regular sex."[9] The prisoner testified that "some of the girls were so desperate to not lose their gain time they would have sexual intercourse" with this lieutenant.

- In February 2017, a Lowell corrections sergeant was arrested and charged with sexual misconduct involving a prisoner, and terminated from employment. After another officer witnessed the sergeant kissing a prisoner in July 2016, the prisoner told investigators that she had sexual intercourse with the sergeant on multiple occasions, and forensic testing ultimately revealed the sergeant's DNA on the prisoner's pants. Another officer investigated the scene and found a letter between the prisoner and staff confirming an inappropriate relationship. Despite this strong forensic and circumstantial evidence of sexual abuse, the charge was subsequently dropped because the victim's refusal to cooperate precluded the state from proving "sexual penetration" as the charging statute requires. However, the sergeant's termination stood, for violating the FDOC moral character standards.

[9] Some prisoners may earn "gain time," resulting in an earlier release date, based on good behavior while in prison.

- A food service coordinator at Lowell Correctional Institution was arrested on September 18, 2019 on suspicion of sexual battery on a prisoner, and charged with one count of battery. Although the charge was subsequently dropped, this alleged battery was corroborated by surveillance video, which showed the staff member "waited until no one was in the immediate area," then "rubs/grabs [the prisoner's] buttocks, while she is still cleaning." The complaining witness was cleaning the kitchen area of the prison, in the middle of the day, when the food service coordinator grabbed the prisoner's buttocks, which investigators subsequently confirmed in reviewing video evidence. At the time of the staff member's arrest, it was reported that DOC officials were in the process of terminating him. Earlier in 2018, a prisoner alleged that another prisoner had engaged in oral sex with this staff member, but OIG closed that case as "unfounded" without interviewing the staff member.

Many more officers at Lowells have been investigated for credible accusations of sexual abuse, including forcible rape, sexual acts in exchange for contraband, and other forms of coerced sexual activity. For example:

- In March 2018, a Lowell sergeant allegedly anally raped a female prisoner in a storage area at Lowell. She alleged that the sergeant forcefully "turned [her] around, pulled [her] pants down and forced his penis in anally, then he wiped himself off on [her] thermals." Extensive evidence, including photographs showing anal trauma, documents the victim's injuries. A forensic examination of the victim after the assault found that she was suffering "back pain" and "rectal pain" and had "loose stool" and "loss of bowel control." An OIG inspector who worked on the case told the Department that Lowell staff mishandled the alleged victim's clothing in the immediate aftermath of her report, so no DNA evidence was collected for subsequent forensic lab testing. Shortly after the alleged rape, the sergeant went on leave; he subsequently resigned from his position with FDOC. As of September 2020—two and a half years after the alleged incident—OIG's investigation remained open.

- One corrections sergeant resigned in 2019 after having been accused of sexual misconduct, violence, and threats against prisoners since 2013, including in at least 10 documented complaints. In March 2017, Lowell's Warden at the time wrote in an email that the sergeant should be removed from the female prisoner population because he "has had multiple allegations of misconduct with several being sexual in nature. There have been 10 assigned as IG investigations with six remaining under open investigation and four not-sustained thus far. . . . While I hesitate to condemn staff solely based on allegations made by inmates and no substantiated cases, the number and trend is certainly concerning." The complaints against the sergeant included an allegation that he "threatened [a prisoner] with bodily harm and slammed her head into a wall," that he sexually abused prisoners including "touching [a prisoner's] buttocks," that he had repeatedly propositioned prisoners for sex and sexually harassed prisoners, that he was having sex with a prisoner who was selling cigarettes for him, and that he exchanged cigarettes, pills, and other contraband for sex with prisoners.

Several of the specific allegations against the sergeant were disturbing. In early 2017, a prisoner in the Lowell Annex made repeated allegations that the same sergeant had repeatedly propositioned her for sex, alleging that he "has asked her on numerous occasions when am I going to . . . let him f--k [me]." She alleged that she was "in fear" of the sergeant and a female officer with whom he was also allegedly involved, and she described specific incidents and alleged that he offered her cigarettes in exchange for exposing her naked body. In another 2017 case, a prisoner's aunt contacted Lowell and reported that her niece regularly was having sex with the sergeant and selling cigarettes to other prisoners for him. In March 2017, due to this pattern of sexual misconduct allegations, including six cases that remained open at the time, the warden requested that the sergeant be placed on "no contact status" or transferred to another facility; he was listed on the "no inmate contact" list from March 2017 until he resigned three years later, and briefly was reassigned to a nearby men's facility. However, he remained employed as a sergeant at FDOC, moving between the Annex, the Main Unit, and other facilities, until he resigned in March 2019. All OIG cases against this former officer have been closed or suspended with no sustained violations.

- In April 2018, a Lowell corrections officer allegedly raped a prisoner in the outdoor space between two buildings. According to the prisoner's written allegation, while she was working in a dormitory in April 2018, the officer "took [her] to a side of the building" between the dorm and the canteen, "pushed [her] down," told her he "knew what kind of girl [she] was," and forced his penis into her mouth: "I did what he told me and gave him oral and he zip[ped] his pants up and took me back to [the dormitory]." The prisoner repeatedly maintained the details of her allegation. In December 2018, she reported that she had been "harass[ed]" by "several officers" for reporting the abuse. OIG ultimately closed the investigation as unfounded.

- Between 2015 and 2019, one corrections sergeant was the subject of at least six investigations into allegations of sexual abuse, sexual harassment, and inappropriate interactions with prisoners, one of which was partially sustained in an OIG investigation. The sergeant repeatedly was placed on the "no inmate contact" list due to these allegations, and was transferred between Lowell assignments and an FDOC men's facility, but returned to positions directly supervising prisoners at Lowell. During on-site interviews with the Department, multiple prisoners accused this sergeant of threatening them with confinement or discipline if they spoke frankly with the Department. Administrators placed the sergeant on "no inmate contact" status, and planned to transfer him, and Lowell's Warden informed the sergeant in April 2019 that permanently reassigning him to the other facility was "in the best interest of Lowell Correctional Institution." That same month, the sergeant voluntarily resigned from the FDOC. Prior to his voluntary resignation, this sergeant—an admitted sexual harasser who was repeatedly accused of sexual abuse over several years—continued working within FDOC. By failing to implement meaningful corrective actions, FDOC and Lowell officials allowed this sergeant to directly supervise prisoners on and off over several years.

The Department also reviewed Lowell staff discipline records, which demonstrate a persistent pattern of sexual misconduct. For example, Lowell staff discipline logs for April and

May 2017 indicate that at least 18 officers and other staff faced discipline for PREA-related violations over those two months, as follows:

- One for "Arrest (sexual relationship with inmate)"
- Ten for "Inappropriate Relationship"
- One for "Conduct Unbecoming (sexually assaulted another person)"
- One for "Conduct Unbecoming (seen inappropriately touching herself in food service area)"
- Two for "Conduct Unbecoming"
- One for "Inmate Abuse (vulgar language against inmates)"
- One for failure to follow reporting procedures after inmate reported being raped
- One for "Failure to Report Violation" for failure to report an inappropriate relationship between another officer and a prisoner

Lowell's "no inmate contact" lists also demonstrate a pattern of sexual predation among staff. Between November 2017 and March 2019, at least a dozen officers and other staff were removed from prisoner contact positions based on credibly alleged or confirmed misconduct apparently of a sexual nature, as follows:

- One for allegations of prisoner assault
- Four for allegations of misconduct, inappropriate conduct, or inappropriate contact with prisoners
- Five for "inappropriate relationship" or allegations of inappropriate relationship
- One for multiple cases, both closed and open, of alleged misconduct
- One for "inmate abuse"

Some of these individuals were arrested, terminated, or resigned while under investigation, while others remained employed at Lowell or other FDOC facilities.

B. Inadequate Systems for Preventing, Detecting, and Responding to Sexual Abuse Place Lowell Prisoners at Substantial Risk of Serious Harm from Staff Sexual Abuse.

Lowell exposes women prisoners to a substantial risk of serious harm from sexual abuse because Lowell: (1) provides inadequate supervision of prisoners, which presents opportunities for sexual abuse to occur; (2) deters prisoners from reporting staff sexual abuse due to the threat of retaliation; (3) fails to respond with appropriate investigations when women do report abuse; and (4) fails to provide effective and confidential reporting mechanisms. A lack of gender-responsive and trauma-informed policies and practices exacerbates these problems and exposes victims to additional harm. These systemic deficiencies combine to result in Lowell's failure to protect women prisoners from the harm of sexual abuse.

1. *Lowell's Policies and Practices Enable Sexual Abuse of Prisoners by Staff by Failing to Ensure a Reasonably Safe Environment.*

a. **Staffing Inadequacies Place Lowell Prisoners at Substantial Risk of Harm.**

Severe staffing shortages at Lowell result in inadequate supervision of women prisoners, exposing them to the substantial risk of harm from sexual abuse. Understaffing is an almost constant problem at Lowell, with designated security posts often left vacant due to inadequate numbers of staff on duty.[10] The Lowell Correctional Institution Staffing Plan provides for security staffing positions at Level I, Level II, and Level III, with Level I positions the most essential. Internal reviews have repeatedly concluded that unless posts at all levels are filled according to the Staffing Plan, supervision and monitoring are inadequate to prevent, detect, and respond to sexual abuse and sexual harassment allegations. In spite of the mandate to ensure that all posts are filled, the actual deployment of staff at Lowell consistently fails to meet adequate staffing levels.

Staff vacancies and staff availability to work are serious problems at Lowell. For example, during a three-day period from February 12-14, 2018, daily security staff rosters for Lowell Main indicated that vacancy rates among security staff were approximately 15 percent; *i.e.*, 15 percent of security posts were not filled at all. On top of these vacancy rates, staff availability to work is extremely low, further reducing the number of staff actually working at the facility. On February 14, 2018, 41 percent of security staff scheduled to work were either on leave, out for training, or on "special assignment," with only 59 percent recorded as "working" their assigned security posts. Only approximately 65 percent of security staff scheduled to work were recorded as working their assigned posts on February 12 and 13, 2018. Daily security staff rosters for Lowell Annex on January 22, 2018 indicated similarly concerning vacancy rates and unmanned posts: vacancy rates among security staff were approximately 14 percent, and only 59 percent of security staff were "working" while 35 percent of filled posts were unmanned. Throughout 2017 and 2018, staff vacancies were recorded at high levels. Reports logging vacant staffing of Level I posts for Lowell Main from January 1, 2017 through December 31, 2017 indicate a total of 1,104 Level I shifts were vacant between January 1 and December 31, 2017, for a total of over 13,000 hours. For the period between January 1 and August 28, 2018, 113 Level I shifts were vacant, totaling over 1,300 hours. The vast majority of these vacancies were housing officer shifts, that is, posts supervising prisoners on housing units.

Lowell's inadequate staffing levels result in security staff frequently being reassigned on an ad-hoc basis to secondary posts, leaving primary security posts vacant. The Staffing Plan indicates that all Level I, II, and III posts should be filled, with additional posts for special assignments, and that these posts should be fully staffed. In practice, however, as noted in the 2018 Staffing Plan, security staff often are reassigned from their designated posts to secondary duties or "special assignments," leaving posts vacant. The Lowell Annual PREA Staffing

[10] In addition to inadequate numbers of staff, Lowell also fails to adequately rotate staff housing unit assignments. The Lowell Warden told us that this lack of rotation leads staff to become "overfamiliar" with the prisoners they supervise, an observation shared by an OIG supervisor. Despite the acknowledgment of this risk, Lowell has not changed its staff assignment practices.

Review identified 141 times in 2017 when staffing levels fell "below critical," meaning Level I posts were left vacant, due to secondary duties. These secondary-duty reassignments can lead to dangerous gaps in security staff coverage. Because open-bay housing units are assigned two supervisory staff each, only one of whom is designated Level I, any time the second assigned officer is redirected to perform secondary duties such as dining supervision, pill line, or escorts, a single officer is left to supervise an entire housing unit alone. This means one officer may be responsible for supervising, on average, anywhere from approximately 60 to well over 100 prisoners.

The problem of staffing shortages at Lowell has been highlighted repeatedly by internal and third-party reviews as a risk factor placing prisoners at risk of sexual abuse. In a 2016 email to the Lowell PREA manager, the FDOC PREA coordinator cautioned that posts were left vacant for hours at a time due to secondary duty reassignments. Serious staffing shortages were also highlighted in a Staffing Assessment conducted in November 2016 by the Association of State Correctional Administrators (ASCA), and in a November 2015 study of FDOC operations ordered by the Florida legislature and conducted by a third-party consultant company. FDOC officials have acknowledged the need to modify staffing levels to provide more relief staff positions so that security staff are not called away from designated posts to perform special assignments. However, severe staffing shortages persist.

Lowell's chronic staffing problems are due in part to a failure to retain qualified staff and a high staff turnover rate, which requires the facility to constantly invest in training large numbers of new staff. Indeed, during the one-year period from May 21, 2018 to May 21, 2019, 149 staff were hired; although the Warden at the time of our first tour told us she had hired over 700 new staff in the previous three years. The continued high staff vacancy rate in spite of this level of hiring demonstrates problems with attrition. Because of the high staff turnover rate at Lowell, staff often are young and inexperienced; the trainee eligibility age was recently lowered from 19 to 18. Our expert noted that such high turnover and high proportion of new, untrained, inexperienced staff leads to instability, prisoners feeling insecure and anxious in their environment, and makes prisoners more vulnerable to predatory behavior.

Lowell's severe understaffing problem results in inadequate supervision and creates an unacceptably high risk of sexual abuse by creating the opportunity for staff to engage in misconduct without detection. The ongoing staffing deficiencies at Lowell create an environment where staff are less likely to notice other staff taking advantage of vulnerable prisoners, and where those engaging in unlawful schemes can easily avoid supervision and camera surveillance. In many cases, sexual abuse has occurred during the night when an officer is supervising one or more housing units alone, or during other times of insufficient staffing coverage.

b. Failure to Secure and Monitor the Physical Plant of Lowell Enables Staff Sexual Abuse of Prisoners.

The effect of Lowell's staffing deficiencies is exacerbated by a physical plant that is replete with blind spots and unsecured areas that are difficult to supervise and provide

opportunities for abuse. In an effort to avoid detection, Lowell staff purposely exploit weaknesses in Lowell's physical structure and security practices to abuse prisoners.

Surveillance camera coverage throughout the facility is inadequate to protect prisoners from unreasonable risk of harm from sexual abuse. Many alleged incidents of sexual abuse and other misconduct have occurred in areas without surveillance camera coverage or with inadequate coverage of entrances and exits. For example, in March 2018, a sergeant allegedly raped a prisoner in a storage room near the foyer area of a dormitory in Lowell Annex; the allegations were supported by extensive photographic evidence and medical records of the prisoner's injuries, but there were no cameras in the foyer area and therefore no surveillance footage to review as part of the investigation.

Lowell's physical plant includes spaces completely out of view of any common areas, security posts, or other people, with no surveillance camera coverage. These spaces include mezzanines, which are large attic spaces running the length of a housing unit dorm, and HVAC rooms. In interviews with the Department and in documented allegations of sexual abuse, these spaces were repeatedly noted as locations of staff sexual abuse of prisoners.

During its first tour, the Department had an opportunity to observe Lowell's physical plant, to include areas where cameras were located, as well as areas that were and were not monitored by a camera.

For example, in one dormitory, the Department observed blind spots on camera angles within the laundry room, as well as an inoperative camera. Also in this particular dormitory, both prior to and during the tour, the Department was made aware of a specific mezzanine where there was an alleged incident of sexual abuse. The Department confirmed not only the absence of any cameras or other monitoring in the mezzanine area, but also observed that the area was a clear risk for incidents of sexual abuse to take place given the size, which extended the length of the dormitory. Additionally, there were also no cameras at the back of this dormitory, such that the door leading to the mezzanine area was not monitored. During the Department's second tour, we noted the absence of any cameras outside of some dormitories. Despite the fact that these areas pose clear risks of sexual abuse, should be off-limits to all prisoners, and repeatedly have been raised to the attention of OIG and Lowell authorities, they remain insufficiently covered by surveillance cameras or other monitoring. Lowell's Warden informed the Department in November 2019 that there are no plans for cameras to be installed in these areas. Although the Warden stated that cameras will be placed on walkways around these areas, that is insufficient and cannot take the place of in-room camera coverage or other monitoring, especially given the frequency of reports alleging the use of these spaces for sexual abuse of prisoners.

The configuration of housing units at Lowell further contributes to an environment where there is an unacceptable risk of harm from sexual abuse, because women prisoners are vulnerable to impermissible cross-gender viewing for reasons unrelated to security.[11] In many of the

[11] The PREA standards requires facilities to "implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing

housing units in Lowell Main and the Annex, including the youthful inmate dormitory, male staff can view the female prisoners while they are showering and using the toilet. In many open-bay housing units at Lowell Main and Lowell Annex, the on-unit officer station is elevated and situated between the two sides of the unit. Male staff in the officer stations have clear visibility into the bathrooms and can view the first rows of toilets. Many showers have saloon-style swinging double doors with a gap in the middle, resulting in women being exposed while showering. In some housing units, windows lining the external corridors allow male staff a view into the toilets and showers. In celled housing units, male officers can view prisoners while they are using the toilet. Some showers are equipped with doors or screens that cover only part of the prisoner's body, from above the knees to below the shoulders of a prisoner of average height. Depending on the height of the prisoner using the facilities, private parts of her body may be seen from outside the shower area. Having a configuration that allows for male staff to engage in prurient viewing of women prisoners while showering or using the toilet can create a sexualized environment that creates a risk of harm of sexual abuse and harassment. For example, several prisoners interviewed complained that male staff frequently comment on their bodies in a harassing manner. When the environment is such that male staff have the ability to view women prisoners under these circumstances on a daily basis, the risk of harm is increased.

Attempts to mitigate privacy violations have been insufficient. For example, in late 2018 or 2019 a frosted film was added to some of the windows of the dorms such that individuals entering the dorm from the outside could not observe the bathroom and shower area. Still, male staff can see into these areas from the officers' station, in part because anyone who is taller than average height can easily see over the frosted portion of the window.

The behavior of Lowell staff exacerbates these privacy violations. Staff can manipulate elements of the physical plant to view women prisoners in the toilet and shower areas. When the Department toured Lowell in November 2019, we observed that the mirrors in one dormitory had been turned so that officers could see directly into the restroom/shower area from their "bubble." The Department compared the configuration of the mirrors in other dormitories and observed that the mirrors faced the entry door area to the dormitory to allow male officers in the officers' station to observe activity in the entryway located behind them. In the dormitory where the mirrors were turned, it was evident that the angle of the mirrors was intended to observe the restroom/shower areas only, as the entry door area was not in view of the mirrors. When we brought this to management's attention, they brought in a maintenance team to adjust the direction of the mirrors, but the problem had been obvious and could have been corrected without the Department commenting.

Male staff also consistently fail to announce themselves when entering a housing unit or other areas where prisoners are showering or getting dressed. Although the 2019 PREA Facility Audit Report indicates that a "majority" of male staff announce themselves before entering an

---

their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to [announced] routine cell checks." 28 C.F.R. § 115.15(d). These prohibitions are intended to prevent staff "voyeurism" which PREA defines as "sexual abuse." 28 C.F.R. § 115.6 ("an invasion of privacy of an inmate… by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions.").

area where prisoners might be undressed, prisoners consistently reported to the Department that this is not the case. Moreover, Lowell staff evinced a lack clarity on the proper protocol for a male officer to announce himself. In interviews with the Department, some officers stated that they believe the protocol is to announce once at the beginning of the shift in the morning, with no obligation to announce again; others informed us that they were required to announce every time a male corrections officer stepped into the housing unit. However, an announcement only at the beginning of a shift is clearly not adequate for providing prisoners with the opportunity to avoid exposure.[12] Similarly, a sign indicating that "male staff may be on duty at any time" is not helpful.[13]

2. *Lowell and OIG Procedures and Practices Discourage Prisoners from Making Reports of Sexual Abuse.*

Prisoner sexual abuse victims who face adverse consequences for reporting sexual abuse are much less likely to report the abuse.[14] We identified this problem at Lowell, where many prisoners the Department interviewed during our investigation informed us that prisoners were "punished" or "feared retaliation" for making allegations against staff. These women's concerns are rooted in fact. Prisoners at Lowell who make sexual abuse allegations routinely are placed in involuntary segregated housing, forfeiting access to regular programming, services, and property. In addition, during our site visits, supervisory staff warned some of the prisoners there would be negative consequences if they cooperated with the Department's investigation.

a. Lowell Routinely Places Sexual Abuse Victims in Involuntary Segregated Housing.

Prisoner victims of sexual abuse are less likely to report the abuse if a facility punishes the reporter. Punishment, as perceived by the reporting prisoner, may take many forms such as loss of programs or privileges, placement in isolation or segregation, and removal of property. Dozens of women reported that they believed prisoners who report sexual abuse are sent to confinement. This belief was corroborated by staff. For example, a sergeant we interviewed stated that prisoners are most definitely placed in handcuffs and taken to confinement after reporting abuse. This same sergeant indicated that prisoners do not get visitation when placed in administrative confinement.

---

12 *See* What is Required by the Cross-Gender Announcement in Standard 115.15(d) and 115.315(d)? National PREA Resource Center (Feb. 19. 2014), https://www.prearesourcecenter.org/node/3262 ("In adult prisons and jails . . . 'staff of the opposite gender' are required to 'announce their presence when entering an inmate housing unit.' This is sometimes referred to as the 'cover-up rule' and is intended to put inmates on notice when opposite-gender staff may be viewing them. … When the status quo of the gender-supervision on a housing unit changes from exclusively same gender, to mixed- or cross-gender supervision, the opposite-gender staff is required to verbally announce their arrival on the unit.").

13 *See id.*

14 The National Prison Rape Elimination Commission reported in 2009 that, in a survey of three Midwestern prisons for women, "[o]nly about one-third of [sexual abuse] victims reported the incidents to prison officials [because] they feared retaliation..." NPREC Report 38, June 2009, https://www.ncjrs.gov/pdffiles1/226680.pdf.

Accordingly, the PREA standards severely restrict the involuntary placement of victims in segregated housing. *See* 28 C.F.R. § 115.68 ("[a]ny use of segregated housing to protect an inmate who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.43."); 28 C.F.R. § 115.43 ("[i]nmates… shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available means of separation from likely abusers." "If a facility cannot conduct such an assessment immediately, the facility may hold the inmate in involuntary segregated housing for *less than 24 hours* while completing the assessment.") (emphasis added). In addition, any use of involuntary segregated housing for victims must be fully documented and justified. *See* 28 C.F.R. § 115.43(d) ("[i]f an involuntary segregated housing assignment is made pursuant to [this standard], the facility shall clearly document: (1) the basis for the facility's concern for the inmate's safety; and (2) The reason why no alternative means of separation can be arranged.").

Prisoners who report sexual abuse at Lowell are routinely placed in Administrative Confinement for days or weeks at a time.[15] While Administrative Confinement is distinct from Disciplinary Confinement, the restrictive nature of Administrative Confinement feels punitive to the prisoner victim. In fact, one of the permitted uses of Administrative Confinement is for the placement of prisoners who have charges pending against them for major rule violations "in order to provide for security or safety. . . ."[16] FDOC's Prison Rape: Prevention, Detection, and Response procedure ("PREA Policy") permits the placement of prisoner victims in Administrative Confinement, even when the prisoner has indicated a preference to remain in general population, if "it has been determined that there are no available alternative means of separation from likely abusers. . . ."[17] In such cases, the confinement must be reviewed by the Institutional Classification Team within 72 hours. [18] However, the PREA Policy also provides

---

[15] The FDOC defines Administrative Confinement as "the temporary removal of an inmate from the general inmate population in order to provide for security and safety until such time as more permanent inmate management processes can be concluded." FLA. ADMIN. CODE ANN. r. 33-602.220(1)(a) (2020). This type of confinement status "may limit conditions and privileges… as a means of promoting the security, order and effective management of the institution." FLA. ADMIN. CODE ANN. r. 33-602.220(2)(a) (2020).

[16] *See* FLA. ADMIN. CODE ANN. r. 33-602.220 (3)(a) (2020).

[17] It appears that the Officer in Charge makes the initial determination that "that there is no available means of separation from likely abuser(s)…" *See* Fla. Dep't of Corr. Prison Rape Elimination Act (PREA) Guide, June 2018, at 17 (on file with the Department). FDOC's current PREA Policy, which became effective on July 31, 2018, represents a significant improvement over the prior version, from 2016, which permitted automatic placement of reporting victims in Administrative Confinement "[u]pon notification" of an incident. The 2016 PREA Policy permitted this placement to continue for *up to 72 hours* before the facility was required to review the placement, alternative options, and the prisoner's housing preference.

[18] "The Institutional Classification Team (ICT) will then conduct a 72-hour review of the named PREA victim. The ICT will further review the inmate and the allegation, verify the inmate's housing preference, and reassess the availability of any alternative housing. If the inmate victim remains involuntarily segregated ICT will ensure proper documentation… related to the basis of the facilities [sic] concern for the inmate's safety and why no alternative means of separation can be arranged." Fla. Dep't of Corr., *Procedure 602.053, Prison Rape: Prevention, Detection, and Response*, § 4(a)(2)(b) (July 31, 2018).

that, under some circumstances, the normal placement review may take up to five days.[19] In any event, in practice, the PREA Policy's requirement that the victim have a choice about placement in confinement pending investigaton often does not occur, as described to us by senior security staff, investigative staff, prisoners, and advocates. Some prisoner victims at Lowell are ultimately placed in Administrative Confinement for several days or weeks. Between January 2017 and June 2018, 24 different Lowell prisoners who were allegedly victims of sexual misconduct were placed in Administrative Confinement for days or weeks pending investigation. They spent an average of more than seven days in confinement; seven different prisoners were held in Administrative Confinement for longer than a week at a time during that period. Some alleged victims were placed in confinement pending investigation multiple times.

Instead of placing alleged victims in Administrative Confinement, Lowell could temporarily reassign the accused staff, or place the accused staff on no-contact status with the prisoner victim or on paid administrative leave pending outcome of the investigation. Another available option is to move the prisoner victim to another general population housing unit where the accused staff does not have access.

Placement in Administrative Confinement at Lowell involves considerable restrictions on privileges and programming. For example, "telephone privileges are [only] allowed for emergency situations, when necessary to ensure the inmate's access to courts, or in any other circumstance when a call is authorized by the warden or duty warden." FLA. ADMIN. CODE ANN. r. 33-602.220(5)(j) (2020). This is particularly problematic for victims of recent sexual abuse because, absent access to the telephone, the victims have no timely access to the outside confidential emotional support services hotline afforded to general population prisoners.[20] In addition, lack of telephone access deprives these victims of timely avenues to report retaliation or additional mistreatment to the OIG "TIPS" line and the external Gulf Coast Children's Advocacy Center line.

In addition, procedures regarding Conditions and Privileges in Administrative Confinement provide considerable discretion in restricting privileges generally enjoyed by prisoners in general population housing units. For example, personal property, comfort items, canteen items, and visitation may be restricted if "there is an indication of a security problem" or at the discretion of the ICT, warden, or warden designee. In practice, multiple prisoners reported to the Department that it was typical and expected that they would lose canteen items, access to phones, visitation, programming, and other privileges when they were placed in Administrative

---

[19] The Rule permits an exception for the 72-hour review "when the ICT cannot complete its review within the allotted timeframe due to a holiday. If the review cannot be completed within 72 hours, the action of the senior correctional officer shall be reviewed within 72 hours by the duty warden . . . and evaluated within 5 days by the ICT. Inmates placed into administrative confinement shall not be released from this status until approved by the ICT." FLA. ADMIN. CODE ANN. r. 33-602.220 (2)(c) (2020).

[20] PREA posters in general population housing units inform prisoners: "Lowell Correctional Institution has partnered with Domestic Violence/Sexual Assault Center of Ocala/Creative Services, Inc. to provide survivors of sexual abuse with emotional support services." The posters provide a phone number and a post office box mailing address.

Confinement, which is why they were afraid to make PREA allegations. *See generally* FLA. ADMIN. CODE ANN. r. 33-602.220(5) (2020). As discussed below, one prisoner told us that she did not report sexual harassment because it would mean placement in Administrative Confinement, which would result in her forfeiting a scheduled visit with her son.

During the course of our investigation, staff, prisoners, and victim advocates told us in chorus that making a report of sexual abuse means going to confinement. While Lowell increasingly utilizes the "PREA Victim Housing Preference" form DC6-2084 to determine whether placement in Administrative Confinement would be voluntary or involuntary, we were told repeatedly that prisoner preferences are ignored.[21] In November 2019, a senior corrections supervisor informed us that prisoners are "always" sent to segregation if they report a PREA-related allegation involving a staff member, "even if the inmate says she does not want to go." In 2020, OIG staff informed us that they routinely (but not always) order prisoner victims into Administrative Confinement for as long as necessary to complete an investigation or determine continuing risk to the victim. OIG indicated that, until they have an opportunity to interview the victim, they do not necessarily consider the preferences of the prisoner, and that security staff sometimes fail to accurately document their justification for the placement order.[22] The prisoners, however, perceive this prolonged confinement as punitive and the effect is to discourage prisoners from reporting sexual abuse.

b. Lowell Supervisory Staff Threatened Prisoners About Cooperating with DOJ Personnel.

During the Department's onsite visits to Lowell, we received information that supervisory staff had threatened prisoners against cooperating with our investigation, and in one case retaliated against a prisoner for providing us with information.

During our August 2018 tour, we learned that a sergeant, who was the subject of a long list of PREA-related allegations, had warned prisoners in Dormitory A not to speak with Department attorneys and investigators visiting Lowell. Specifically, several prisoners reported that the sergeant warned the prisoners to "be careful what you say because you may end up under investigation." In this case, the Warden took the unusual measure of writing a letter to the sergeant indicating that his permanent reassignment to a different FDOC facility was "in the best interest of Lowell Correctional Institution." The sergeant voluntarily resigned from FDOC in April 2019.

During our November 2019 tour, a prisoner approached the Department's team, and stated that a sergeant, who also was the subject of several PREA-related allegations over a number of years, was repeatedly sexually harassing her but she was afraid to report it because

---

[21] Because Lowell does not offer meaningful alternatives to Administrative Confinement, prisoners are generally left with the choice of returning to the housing unit where the alleged staff perpetrator may be stationed, or agree to being placed in Administrative Confinement.

[22] OIG staff informed us that the facility sometimes places victims in Administrative Confinement without such an order being issued by OIG, and that facility staff nevertheless will state in their written justification for the placement "per OIG."

she was going to be getting a visit from her son and did not want that to be taken away. The team reported this to facility leadership. The next day we learned that the reporting prisoner had been placed in Administrative Confinement. The prisoner's mother had called the shift supervisor that night, stating she feared for her daughter's life because the sergeant made threats against her daughter when he found out her daughter talked to Department personnel. This same sergeant was reported by several prisoners to have said to prisoners during the morning count that "you can keep telling DOJ your lies, it doesn't matter how much trouble I get in, I can retire and lay at home." The team relayed this information to the Warden who then released the prisoner from Administrative Confinement and transferred the sergeant to a different FDOC facility.

While the Department's team was able to speak with a number of prisoners while onsite, dozens of others declined to be interviewed, expressing fear of being seen cooperating with our investigators. And many of the prisoners with whom we spoke similarly indicated that they were fearful that they would be retaliated against.

3. *Lowell's Inadequate System for Investigating Reports of Sexual Abuse Subjects Prisoners to Substantial Risk of Harm.*

Despite an investigations policy that is adequate on paper, Lowell fails to meaningfully investigate allegations of sexual abuse. The inadequacies identified include: closing cases without conducting appropriate investigation of available evidence, closing cases upon the accused staff's termination or resignation, delays in reviewing and investigating allegations, and inaccuracies in documenting and tracking employee terminations and dismissals.

a. Investigations Are Closed, Suspended, or Disposed of with Minimal Disciplinary Action After Inadequate Investigation of Available Evidence.

Many sexual abuse allegations are closed prematurely based on OIG's determination that allegations are "unfounded" after taking only preliminary investigative steps. Of the 161 sexual misconduct cases we reviewed, more than half were closed as "unfounded"—78 at the pre-investigation "complaint review" stage and 6 after being opened as criminal investigations. All but a handful of the "unfounded" cases reviewed contained conclusory findings based on insufficient factfinding, such as failing to interview the alleged perpetrator and potential witnesses; many contained conclusory assertions that no surveillance footage was available to review or no additional potential witnesses could be identified, without explanation as to what efforts were made to identify such evidence.

Many of the cases that OIG summarily closed as "unfounded" were based on third-party and anonymous complaints and grievances where the victim denied the allegations when first questioned. Although an uncooperative victim may present challenges to a criminal investigation, it is essential to follow through with an administrative investigation in these circumstances. Adequately investigating all allegations helps to protect against potential sexual abuse of a vulnerable population who may understandably be reluctant to report against those who have authority over them. Prisoners may also fear discipline if they admit, for example, to exchanging sex for contraband or other allegations that the prisoner broke prison rules. Third-

party or anonymous complaints and grievances may be the first indication of a problem where the victim herself is too fearful to come forward. In practice, however, a full investigation does not occur. An OIG inspector acknowledged in an interview with the Department that inspectors often close cases as "unfounded" after interviewing only the alleged victim. This blunt assessment was consistent with the individual cases we reviewed. For example:

- In 2018 an anonymous note reported that a prisoner was having sex with a corrections sergeant in exchange for cigarettes. When she was interviewed, the prisoner admitted that she had sold cigarettes to other prisoners, but "denied knowing" where the cigarettes came from and denied having had sexual contact with the sergeant. The case was closed as unfounded at the complaint review stage. Despite the prisoner's dubious statements regarding the source of the cigarettes, no futher interviews were conducted, and the prisoner's admission that she was selling contraband apparently was not investigated further. (The investigation documents indicate no discipline of the prisoner for the contraband violation, although the complaint review report indicates that the sergeant disciplined her for tattooing.) Although the anonymous report contained details about the date, time, and location of an alleged private encounter between the prisoner and the officer in an "A/C room," the inspector does not explain whether any surveillance video was sought or reviewed.

- In April 2019, OIG closed a complaint as unfounded although the inspector interviewed only one alleged victim. Specifically, a third-party grievance filed in November 2018 alleged that a prisoner was involved sexually with a corrections officer and, separately, with two other prisoners, one of whom was a "Youthful Offender." An inspector interviewed the prisoner victim in April 2019, and she denied the allegations and claimed never to have witnessed any staff sexual abuse of any kind at Lowell. The inspector closed the case as unfounded without interviewing the alleged perpetrator, who was named in the complaint. The inspector noted that no dates or times were given to permit review of surveillance video, although the inspector does not explain if any attempt was made to identify relevant dates, times, and locations based on the allegations made.[23] In

---

[23] For example, the grievance alleged that the prisoner was having sex with a "Youthful Offender" during her work shifts in the bathroom, but there was no attempt to identify any youthful inmates who worked the same shift as the alleged victim, or to review surveillance video footage from the alleged victim's work shifts. OIG had an extra burden to pursue these allegations to the furthest extent possible because, in addition to sexual abuse of inmates by staff, they potentially involved sexual abuse of a minor by an adult prisoner. FDOC considers prisoners between the ages of 14 and 24 "youthful" inmates. *See* FDOC, Lowell Correctional Institution, General Information, http://www.dc.state.fl.us/ci/314.html. Although allegations of sexual misconduct between prisoners are outside the scope of the Department's investigation, the apparent failure to investigate allegations of sexual abuse of a youthful inmate is consistent with other problems identified in the Department's investigation, in particular severe staffing problems resulting in inadequate supervision of prisoners. Under Florida statute, any person who "has reasonable cause to suspect that a child is abused . . . by . . . [a] person responsible for the child's welfare . . . is a mandatory reporter" of the abuse to the Florida Department of Children and Families. *See* § 39.201. The statute defines "child" as "any unmarried person under the age of 18 years who has not been emancipated by order of the court." § 39.01; *see also* PREA standard 61(d) ("If the alleged victim is under the age of 18 . . . the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws."). 28 C.F.R. § 115.61(d). There is no evidence that anyone at FDOC reviewed this matter to determine the age of the youthful inmate mentioned in the grievance, and if a referral should have been made.

short, the inspector closed the case as unfounded without taking adequate investigative steps.

The risk of harm from these inadequate reviews and conclusory findings is not theoretical; the risk of harm is apparent in several cases of Lowell officers who remained in their positions for years, despite serious allegations that were inadequately investigated. Some of these officers later were criminally charged, terminated, or investigated again for sexual assault and other grave abuse. For example:

- A Lowell sergeant, who remains under investigation based on credible and corroborated allegations that he forcibly anally raped a prisoner in March 2018, was previously accused of other sexual misconduct in cases that OIG closed as unfounded without adequate investigation. In 2017, OIG closed as unfounded a case against the same sergeant in which two prisoners reported that the sergeant had sexual intercourse with and received oral sex from a third prisoner. The complainants reported specific dates and other details. OIG closed the case as unfounded after the alleged victim denied the allegations; OIG did not interview the sergeant, the complainants, or other available witnesses.

- A Lowell sergeant, who was arrested in February 2017 on charges of having sexual intercourse with a prisoner, had been the subject of numerous allegations for years, some of which had been closed by OIG as unfounded despite being inadequately investigated. For example, in January 2016 a prisoner accused the sergeant of receiving oral sex from another prisoner in the bathroom of a Lowell dormitory; the sergeant denied the allegations in a written statement and the alleged victim claimed in a written statement that she had been joking when she told another prisoner that she had performed oral sex on the sergeant. OIG closed the case as unfounded without conducting any in-person interviews and without reviewing any surveillance footage.

In other cases, OIG effectively ends investigations by indefinitely "suspending" them, including cases involving serious sexual abuse allegations. An OIG inspector supervisor told our expert that OIG sometimes suspends cases that cannot proceed unless new information becomes available. In practice, however, it appears that some suspended cases were not adequately investigated. For example, in March 2019, a prisoner alleged that she had been sexually abused by a Lowell psychiatrist during medical appointments over a period of six months. The prisoner alleged that she performed oral sex on the doctor and that he digitally penetrated her and touched and sucked her breasts. The prisoner also alleged that the doctor gave her candy, chips, makeup, and cough drops. The prisoner and the doctor were the only people interviewed. The prisoner maintained her allegations; the doctor admitted he had given the prisoner a cough drop, but denied everything else. No further investigation was conducted, and the case was suspended. OIG did not make any determinations as to whether medical call-out logs corroborated the prisoner's accounts, whether the prisoner had an unusually high number of appointments with the doctor, or whether the prisoner was able to make appointments more easily than other patients. No other medical staff were interviewed to inquire about the doctor's behavior. The doctor's office was not searched. The report details no efforts to identify other potential victims,

such as other patients who saw the same doctor around the same time, or any corroborating witnesses.

OIG also has closed cases or stopped investigating sexual abuse allegations without making investigative findings, upon employees' dismissal or resignation. Separation of a staff member under investigation does not alleviate FDOC's responsibility to investigate allegations of sexual abuse. A number of staff who allegedly sexually abused prisoners have been dismissed or resigned while under investigation, instead of being terminated for cause based on investigative findings. In some of these instances, OIG terminated its investigation or failed to make progress investigating what may have been criminal misconduct. According to FDOC data, two officers in 2017 and one in 2018 resigned or retired while being investigated. In 2017 and 2018, five more were involuntarily "terminated for violating agency policy," one resigned "in lieu of separation" for cause, and several more voluntarily separated for unspecified reasons other than misconduct. Among officers whose separations were "voluntary" or otherwise did not officially indicate misconduct, the Department identified several who previously had been accused of sexual abuse in investigations that ended inconclusively. The Department also identified additional examples of investigations stalling or closing without findings due to staff resignations. For example, several officers and other staff were involuntarily dismissed for "excessive absence" or failure to report; the Department's separate review of individual cases has identified at least one case where an officer was terminated for unexcused absences following investigation for sexual abuse allegations. By allowing sexual predators to resign quietly or terminating them for ambiguous "policy" violations, instead of making a finding of sexual misconduct and terminating them for that reason, FDOC fails to deter criminal behavior and sends a message to other officers that punishing sexual misconduct is not a priority.

In underexploring or ignoring potential available evidence in sexual abuse cases—whether ultimately making an improper "unfounded" determination, leaving a case open but "suspended" for years, or abruptly closing a case by dismissal or resignation without completing the investigative process—OIG fails to provide accountability and direction to the facility administration to implement monitoring for retaliation and corrective action to prevent future sexual abuse. Making investigative findings can trigger important remedial actions to prevent future incidents of sexual abuse and harassment in confinement settings. These specific determinations drive requirements for notice to the victim about the result of the investigation;[24] notice to prospective employers if an allegation against a staff member was substantiated or if he or she resigned during a pending investigation of sexual abuse;[25] consideration of both substantiated and unsubstantiated incidents in the facility staffing plan;[26] retaliation monitoring;[27] and the sexual abuse incident review process.[28] Lowell's insufficient investigative

---

[24] *See* 28 C.F.R. § 115.73.

[25] *See* 28 C.F.R. § 115.17.

[26] *See* 28 C.F.R. § 115.13.

[27] *See* 28 C.F.R. § 115.67.

[28] *See* 28 C.F.R. § 115.86.

findings also hinder the facility from taking steps to protect vulnerable prisoners by taking appropriate remedial actions to prevent future sexual abuse.

Similarly harmful are cases where serious misconduct was identified, but trivial discipline, if any, was imposed. For example:

- In 2017, a Lowell corrections officer was investigated based on allegations that she was having an inappropriate relationship with a prisoner; OIG found that the officer failed to maintain a professional relationship with a prisoner and failed to report receiving personal phone calls from the prisoner's family members. Among other allegations, witnesses reported that the officer had begun a "relationship" with this prisoner when the prisoner previously was a youthful inmate at Lowell. Despite these sustained findings, the officer was disciplined only with a 48-hour suspension. OIG subsequently opened another investigation, in 2018, into allegations that the same officer was sexually abusing another prisoner, including allegations that she engaged in oral sex with the prisoner numerous times and gave the prisoner gifts. The officer later was dismissed for failure to report to work for almost two months while under investigation.

- In 2016, a corrections sergeant told a prisoner, twice, to "Eat a dick." Another officer reported the inappropriate language and also that the sergeant, after "peeping" around corners to ensure he was unobserved, entered a restroom area that the prisoner had entered, and that the two were alone together in the restroom area for several minutes. The officer also reported that the sergeant and the prisoner were acting overly familiar with each other in a common area. Despite the officer's detailed contemporaneous report, OIG subsequently found insufficient evidence to support a finding of sexual misconduct based on review, three months later, of surveillance video, because the video did not show the sergeant and the prisoner engaging in sex acts or going into a private area together.. The sergeant admitted he had made the crude comments and was disciplined with a 12-hour suspension. This individual remains a sergeant at Lowell and his name appears repeatedly in prisoner sexual misconduct complaints, including allegations that he engaged in sex acts with prisoners in exchange for contraband, and that he verbally abused or sexually propositioned prisoners.

Failing to impose discipline commensurate with misconduct allows potential abusers to stay in contact with and supervise vulnerable prisoners, and may embolden some staff to engage in abuse while discouraging others from reporting misconduct.

b. Investigations Often Are Inordinately Delayed.

We identified other serious inadequacies in OIG's investigations practice. Notably, there are significant delays in opening sexual abuse cases after OIG becomes aware of allegations, which place prisoners at risk of continuing serious harm even after they report abuse.[29] OIG's

---

[29] Investigative delays long have been a problem at Lowell. In late 2015, a previous FDOC Inspector General departed under a cloud of criticism that his office delayed or thwarted investigations of suspicious deaths and complaints of abuse. In April 2016, the State announced the appointment of a new Inspector General, who in turn

central intake unit conducts the first line of review of allegations before complaints are assigned to field offices, where they are then reviewed by OIG inspectors to determine whether a full "investigation" should be opened. While the centralized intake unit helps relieve the workload in field offices, staffing of the central intake reviewers may not be adequate. There are six staff to review all complaints; in the 2016-2017 fiscal year, OIG's centralized intake unit received 10,214 total cases and 4,191 TIPS line calls reporting allegations (including sexual abuse and other complaints)—a tremendous workload that inevitably results in cursory review of many allegations and causes delay at the first step of the investigative process. We found cases in which delays between an allegation being intered into the system as an incident and receipt by the OIG Lowell field office lasted several days or longer during which prisoners remained vulnerable to alleged abusers.

Even once investigations have been referred to OIG inspectors and are underway, they can be delayed for long periods. Statistics on the outcomes of staff sexual abuse cases in Lowell's PREA corrective action plans indicate that the majority of PREA allegations remain under pending investigation for years on end. In 2017, Lowell had 21 documented allegations of staff sexual misconduct, 16 of which were still in an ongoing investigation as of January 10, 2019. In 2018, there were 44 cases of staff sexual misconduct, 34 of which were still in an ongoing investigation as of January 10, 2019. Our review of individual case timelines also indicates serious delays in investigating cases. For example, on November 14, 2018, an anonymous third party filed a grievance alleging that another Lowell prisoner was having a "sexual relationship" with a corrections officer, who was named in the complaint. The case was assigned for complaint review on November 16, 2018, but it took five months, until April 16, 2019, for the alleged victim to be interviewed by an inspector, only for the case to be closed as unfounded at the complaint review stage, based on the alleged victim's denial of the allegations and lack of further interviews or other investigation.

The OIG also is under-resourced, leading to high turnover and too few inspectors to adequately investigate the volume of cases. In fiscal year 2017-2018, department-wide, 106 investigative staff maintained an average individual caseload of 250 distinct matters.

Investigative delays can have serious consequences. A timely and responsive investigatory review process, which Lowell has failed to ensure, is essential to identifying contributing factors to sexual abuse and recommending any changes to policy or practice to help prevent such incidents of abuse in the future. These overly long investigation timelines result in alleged abusers sometimes remaining in close contact with and supervising prisoners, with prisoners at risk of harm on an ongoing basis. Potential witnesses may over time forget details of an incident. Video footage is overwritten after 15-30 days and therefore unavailable if a victim does not come forward until several weeks after an alleged incident. Where DNA evidence of sexual abuse may be available, prompt action is critical to avoid spoliation of highly relevant evidence. Moreover, delay in investigating allegations of sexual abuse can directly result in the alleged victim's continued exposure to risk because the alleged perpetrator remains in their position until action is taken. We identified investigations that were inordinately delayed for

left the position in 2020 and has been replaced by an Interim Inspector General. Despite these changes in top personnel and to the complaint review process, serious delays persist, as described herein.

several years, for no apparent reason. Delay sends a message to staff and prisoners that prompt action may not be taken and abuse can continue to occur.

c. Recordkeeping Inaccuracies Hinder Adequate Investigation.

Recordkeeping inaccuracies contribute to inadequate investigation systems. We reviewed incomplete case files in which dates and times of interviews were not recorded, or basic paperwork, such as case closure notifications to prisoner complainants, appeared to be missing. OIG tracks and aggregates data on investigations, but these reports contain errors that hinder FDOC's ability to prevent and respond to sexual abuse. One consistent problem is that FDOC fails to track terminations of officers who were dismissed or resigned while under investigation for sexual abuse. Our expert identified reports on dismissals that contained significant inaccuracies. For example, a spreadsheet documenting employee terminations and dismissals from July 2015 through June 2018 did not include an officer who other records confirm was dismissed for cause, related to sexual misconduct allegations and other misconduct, in 2016. In the spreadsheet we reviewed, a reason for separation was not recorded for approximately one-third of the cases listed. The inaccurate tracking system and vague or missing information about terminations mean finding relevant information on abusive officers is difficult.

Moreover, FDOC does not track the number of sexual abuse claims against each officer. In an interview with the Department in November 2019, Lowell's then-warden reported that OIG was responsible for tracking such information, but OIG told the Department that it did not track the number of complaints against officers and did not know whose responsibility it was to do so. Additionally, personnel files on Lowell officers are maintained off-site at another FDOC location, so records of counseling memoranda, adverse actions taken, or other indicia of sexual abuse complaint prevalence about a particular officer may not be readily accessible through Lowell's official tracking systems.

4. Lack of Adequate Reporting and Emotional Support Systems Discourage Lowell Prisoners from Reporting Sexual Abuse and Accessing Needed Services.

Sexual abuse reporting and emotional support systems are only effective if prisoners are provided with clear, accurate, and uncontradicted information regarding those systems. During our investigation many prisoners informed us that, for a variety of reasons, they did not trust these systems at Lowell and that they would not report sexual abuse and harassment allegations or seek outside support services. We identified a number of serious flaws with these systems.

a. Lowell Fails to Provide Prisoners with Sufficient Timely and Confidential Access to PREA Reporting Hotlines.

Prisoners who have been sexually abused require timely and confidential methods to make a report. Such reporting permits the victim to receive protection, obtain medical care, preserve forensic evidence, and obtain victim advocacy services. At Lowell, the window to make timely and confidential reports is extremely narrow and revolves around access to the telephones outside secure living units.

Posters in the prisoner living areas list six avenues to make a report of sexual abuse. One avenue is to tell any staff member, which would be highly inappropriate if the staff member was the alleged perpetrator. Due to the typical inability of the facility to staff housing units with more than one correctional officer, the offending officer may be the only staff person that inmates could report to during the officer's shift. Another avenue is to submit a grievance or a prisoner request, which are not designed to address urgent or exigent needs and are also received by a staff member.[30] A third avenue is to report to the facility's PREA Compliance Manager (PCM), which would depend on the PCM's schedule and the prisoner's access to her/him. The remaining ways that a prisoner could initiate an urgent report would be to call the external Gulf Coast Children's Advocacy Center line, call the TIPS line, or call a "family member, friend, legal counsel, or anyone else outside the facility."[31] However, during weekdays, prisoners are only permitted to use the phones from 5:00 p.m. through 11:00 p.m., and only in specific locations near the prisoner living unit.[32] For prisoners relying on the phone system, this could create a delay of several hours after the time of victimization.

For serious incidents of sexual abuse, such delays in reporting potentially place victims in grave danger and may compromise the investigative process.

b. Lowell Fails to Provide Prisoners with Clear Information Regarding Avenues to Report Sexual Abuse to an *External* Entity, Instructions on Maintaining *Anonymity* if Desired, and Access to Outside Confidential Support Services.

Prisoners who have experienced sexual abuse may not trust internal reporting mechanisms and may feel that agency or facility personnel will ignore or cover-up an allegation, or may fear retaliation for reporting to agency staff. Similarly, prisoner victims seeking confidential emotional support services know that providing information to facility mental health providers will result in a formal report of victimization raising identical fears of cover-up and retaliation by staff. Accordingly, PREA requires agencies to provide both an effective external

---

[30] For example, the "Assistant Warden has 20 calendar days after receipt [of a grievance] to respond."

[31] Gulf Coast is a certified Rape Crisis Center, and has been serving as the FDOC external reporting entity for approximately two years. Gulf Coast confidentiality provisions require affirmative signed consent from the prisoner prior to reporting the details of an allegation back to the facility. This would appear to prevent it from being "able to immediately forward inmate reports of sexual abuse and sexual harassment to agency officials," as required by the PREA Standards. 28 C.F.R. § 115.51(b). In any event, even if Gulf Coast was able to meet this requirement, it would be irrelevant so long as prisoners are not informed of the mechanism for prisoners to maintain anonymity when using this option. Seperately, prisoners could also write to someone outside the facility, but that would not address an urgent situation.

[32] The Lowell Handbook makes clear that prisoners "are prohibited from using any phone except the phone in their dorm." Telephone hours are listed as 5:00 p.m. through 11:00 p.m. on Monday through Friday. (Additional hours are permitted on Saturday and Sunday.) The Handbook also indicates that prisoners are "required to place your name on the telephone list and are only to make calls during that time period." Investigative staff informed us that telephones are disconnected outside of the designated hours.

reporting mechanism, and effective and confidential access to an external entity for emotional support services.[33]

Prisoner education materials regarding anonymous external reporting and access to outside confidential emotional support services for Lowell prisoners is, on the whole, incomprehnsible. We identified incomplete, inaccurate, and contradictory information about prisoner reporting, anonymity, and outside confidential support services among the various prisoner and staff educational material we were provided. These materials included the RCP Handbook, the Lowell Handbook, educational posters within housing units, the FDOC PREA Guide, the PREA Education Facilitator's Guide, and the Sexual Abuse Awareness pamphlet.

Conflicting information about the nature of the anonymous external reporting mechanism and avenues to access confidential support services not only creates distrust among prisoners, but also confuses staff and increases the potential for staff to further misinform prisoners. In fact, Lowell's external reporting entity, Gulf Coast, has received only about six calls from Lowell prisoners in the two years it has been serving as a reporting entity—a number certainly incongruous with the prevalence of prisoner allegations at the facility.

Prisoners are unlikely to engage in access to needed outside emotional support services if they believe that any such communications will be monitored or recorded by facility personnel.

C. Officials at Lowell Knew of the Risk to Prisoners from Staff Sexual Abuse and Disregarded It.

Officials at FDOC and Lowell have been on notice of incidents of staff sexual abuse of prisoners for years and have failed to reasonably address the deficiencies that enabled the abuse to occur. By disregarding the obvious risks to prisoner safety, officials at Lowell evinced a deliberate indifference to prisoners' constitutional rights that enables staff sexual abuse of prisoners to continue. *Farmer*, 511 U.S. at 842.

While the Department's investigation focused on credible allegations of officers sexually abusing prisoners from 2017-2019, many of which resulted in findings of wrongdoing, officer arrests, and/or criminal charges, the problems are longstanding and FDOC officials have been aware of a pattern of sexual abuse for years. In December of 2015, a series of Miami Herald articles focused on Lowell and reported widespread abuse of women prisoners. The articles discussed conditions at Lowell dating as far back as 2005. The series uncovered numerous incidents of sexual abuse and harassment by FDOC staff on prisoners based on interviews of Lowell prisoners, both current and former, and a review of misconduct reports filed against FDOC offícals at Lowell, personnel files, prisoner histories, criminal records, as well as investigative reports. Prior to the publication of the series, FDOC released a statement acknowledging that FDOC worked with the Miami Herald in providing thousands of pages of public records and answering hundreds of inquiries regarding its facilities. Included in the statement was a comment from then Secretary Julie Jones who acknowledged that prior to her

[33] *See* 28 C.F.R. §§ 115.51(b); 115.53(a). These Standards are sometimes conflated, but represent two distinct requirements in the standards and serve entirely different purposes.

taking over in January 2015, Lowell was "poorly managed" and lacked the leadership necessary to properly operate a correctional instititution. Publication of the Miami Herald series put FDOC and Lowell on notice of the risk to prisoners from staff sexual misconduct, and the State responded by approving funding for capital improvements, including increased camera coverage; appointing a new warden at Lowell; reporting staff firings or disciplinary actions at Lowell; and requiring review procedures when prisoners were placed into confinement after making a claim of sexual misconduct. However, these piecemeal measures were not reasonable steps to meet FDOC's constitutional obligation to protect women at Lowell from sexual abuse by staff. Significantly, no reasonable steps have been taken to address long-standing staffing inadequacies regarding security or investigative staff. Nor have specific remedial measures been reasonable; for example, while additional cameras may have been added from time to time, FDOC has known that staff have used mezzanine areas at Lowell for sexual encounters with prisoners, but have not installed cameras to cover those areas. Further, despite the installation of a new warden following the Miami Herald article, systemic deficiencies in protecting prisoners from sexual abuse continued to place prisoners at risk of harm. Lowell prisoners remain at serious risk of harm from staff sexual abuse, and FDOC has not taken reasonable efforts to address this risk.

In addition, officials at FDOC and Lowell were aware of dozens of incidents dating back to 2013 in which Lowell officers were alleged to have engaged in sexual misconduct with prisoners, but failed to take action to address the systemic issues with sexual abuse at Lowell. In 2017, problems with the risk of harm to prisoners from staff sexual abuse and the disregard of this risk persisted. For example, in March 2017, the warden sent an email addressing an officer at Lowell who, at the time, had multiple allegations against him with many of them being "sexual in nature."[34] At that time, of the ten investigations against the officer, six remained open. While this officer was ultimately relocated to another facility, it took ten allegations including allegations involving sexual misconduct before action was taken against the officer. Yet, in November 2019, when the Department asked who was responsible for tracking the number of PREA allegations against a staff member to identify potential issues with staff misconduct, an OIG inspector told us that there was no such system in place. In our review of Lowell investigatory files, we saw no evidence of reasonable corrective action by Lowell even though instances of sexual abuse continue to occur along repeated factual patterns.

In particular, OIG has put Lowell officials on notice of Lowell's delinquent or non-existent reponse to allegations of sexual abuse. For example:

- In December 2017, while notifying officials at Lowell of outstanding PREA allegations in which no action had been taken in response, OIG noted that "this has become a constant issue."

- In October 2017, an OIG inspector notified the Lowell Warden and a colonel[35] that a PREA number had not been generated and post-rape guidelines had not

---

[34] Email from Warden to Regional Director, Mar. 15, 2017 (on file with Department).

[35] Colonel is the highest officer rank in FDOC, above major, captain, lieutenant, sergeant, and corrections officer; and below assistant warden and warden.

been followed for a prisoner's allegation that a staff member had raped her. The OIG inspector noted that he had not received a sexual misconduct incident report or prisoner statement, even though the prisoner had made serious PREA allegations against a staff member. The report had initially been handled as only a use of force allegation, even though it contained PREA allegations, resulting in unjustified delay in handling an urgent PREA matter. OIG's Emergency Action Center (EAC), which receives emergency complaints, also had not been made aware of the rape allegation, according to the OIG email despite the allegation being reported.

- In late November 2017, OIG notified top officials at Lowell that a prisoner called the TIPS line in late October 2017 and again in early November 2017 to report sexual abuse, but as of late November 2017, nothing had been done by the facility with regard to the allegations.

Lowell did receive a successful external PREA audit in 2019.[36] However, "passing" a PREA audit does not ensure that a facility is constitutionally compliant. The PREA Final Rule makes clear, "[t]he standards are not intended to define the contours of constitutionally required conditions of confinement. Accordingly, compliance with the standards does not establish a safe harbor with regard to otherwise constitutionally deficient conditions involving inmate sexual abuse." 77 Fed. Reg. 37106, at 37107 (June 20, 2012). In addition, while Lowell took some measures to address deficiencies raised by the PREA audits, Lowell's severe staffing

---

36 Lowell's 2016 Final PREA Audit Report, issued on or about November 4, 2016, identified two areas of PREA noncompliance. *See* http://www.dc.state.fl.us/PREA/Lowell2016.pdf at 4. The auditor issuing this report was decertified by the Department on February 14, 2019 for "[f]ailure to comply with the PREA audit methodology requirements." *See* https://www.prearesourcecenter.org/audit/list-of-certified-auditors. The second Final PREA Audit Report was issued on July 8, 2019. *See* http://www.dc.state.fl.us/PREA/Final%20LCI%20PREA%20Report%20OAS.PDF.

The auditor issuing the 2019 report remains certified by the Department. This audit was contracted through an entity known as PREA Auditors of America LLC (PAA). *See* http://www.dc.state.fl.us/PREA/Final%20LCI%20PREA%20Report%20OAS.PDF; https://preaauditing.com/. Public records indicate that PAA is the recipient of a contract for the Bureau of Prisons, and also maintained contractual relationships for PREA audits with the U.S. Air Force and the U.S. Navy. *See* https://govtribe.com/vendors/prea-auditors-of-america-llc-76nt3.

Press reports indicate that PAA has conducted at least 11 PREA audits of Alabama Department of Corrections (ADOC) facilities starting in 2016 with the Julia Tutwiler Prison for Women. *See* https://www.al.com/news/2016/10/audits_claim_alabama_prisons_m.html. The Department of Justice opened an investigation into allegations of, among other things, "prisoner-on-prisoner sexual abuse" in October 2016, and concluded its investigation in April 2019 finding that ADOC engages in a pattern or practice of violating "the Eighth Amendment of the United States Constitution by failing to protect prisoners [from] prisoner-on-prisoner sexual abuse…" https://www.justice.gov/crt/special-litigation-section-case-summaries/download#Alabama_men.

The PAA leadership team includes a named President and Vice President. https://preaauditing.com/. Neither of these leadership team members are certified by the Department to conduct PREA audits. *See* https://www.prearesourcecenter.org/audit/list-of-certified-auditors. Nevertheless, the Vice President's description on the PAA website states: "With over 35 years of detentions experience, [the Vice President] *sets the standards and leads the auditing team for PAOA.*" (emphasis added).

deficiencies, discussed above, remain unremedied, despite the notice provided by the 2016 PREA audit and additional reports noting the serious risk to prisoners posed by Lowell's understaffing.

On January 10, 2019, an Assistant Warden acknowledged in an email to the Warden at the time and another Assistant Warden that Lowell's 2018 PREA Facility Corrective Action Plan showed that "Lowell doubled in the number of PREA allegations from last year." The Assistant Warden further stated, "I did my best to make the increase in PREA cases sound like not such a bad thing." In November 2019, the Department asked the former Warden, current Warden and an OIG supervisor what steps had been taken to address the increase in PREA allegations from 2018. No one could speak to any steps that had been taken in 2019 to address the issue since the 2018 report came out.

V. MINIMAL REMEDIAL MEASURES

As the efforts by FDOC to address the issues outlined in this Notice have been thus far inadequate to protect women from sexual abuse at Lowell, the following remedial measures are necessary.

- Comply with PREA and its implementing regulations, the National Standards to Prevent, Detect, and Respond to Prison Rape (28 C.F.R. §§ 115 et seq.).
- If it is necessary to hold prisoners who report sexual abuse in Administrative Confinement or other segregated housing in order to keep them safe from further abuse or retaliation, ensure that such prisoners have access to privileges, including telephones, visitation, commissary, programming, vocational opportunities, and outside recreation.
- Ensure that prisoners have internal and external confidential options for timely reporting sexual abuse and sexual harassment, anonymously if requested, including an option that is independent from FDOC.
- Ensure that prisoners receive accurate and complete information and education on how to access all internal and external confidential reporting options.
- Ensure that prisoners who report sexual abuse have access to victim advocates during evidence collection and investigative interviews.
- Ensure that all prisoners have access to confidential external emotional support services related to sexual abuse.
- Develop and implement a system for monitoring retaliation, consistent with the PREA standards, to ensure that persons who report sexual abuse or sexual harassment do not experience retaliation by other prisoners or staff.

- Develop and implement a new staffing plan, taking into account all the factors delineated in 28 C.F.R. § 115.13(a), in order to ensure adequate staffing levels and, where applicable, real-time video monitoring, to protect prisoners from sexual abuse.

- Complete and implement the plan for strategic placement of additional cameras at Lowell, with appropriate oversight and review of camera footage.

- Cameras and video maintenance systems installed should have the capability of retaining video data for not less than 90 days and capacity to store selected video indefinitely.

- Ensure that access to and from the Lowell compound is through secure checkpoints only.

- Ensure that anyone entering the Lowell compound, including staff, undergoes appropriate contraband screening.

- Ensure that all OIG and Lowell PREA investigators and administrators receive specialized training in sexual abuse investigations. Specialized training shall include techniques for interviewing sexual abuse victims, proper use of *Miranda v. Arizona*, 384 U.S. 436 (1966), and *Garrity v. New Jersey*, 385 U.S. 493 (1967), warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

- Ensure that Lowell's Warden has access to investigative files and regular briefings of PREA investigations that include sufficient details so that the facility Warden and/or the incident review team has sufficient information to devise and implement any necessary movement, discipline, or corrective action.

VI. CONCLUSION

The Department has reasonable cause to believe that Lowell violates the constitutional rights of prisoners in its care, resulting in serious harm and the substantial risk of serious harm. Specifically, Lowell fails to protect women prisoners from harm due to sexual abuse by staff. Finally, as explained above, the Department has reasonable cause to believe that Lowell's violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment.

We look forward to working cooperatively with the State of Florida to ensure that these violations are remedied. We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.