Marjory Stoneman Douglas High School Public Safety Commission

Draft Findings & Recommendations

Initial Report

Submitted to the Governor,

Speaker of the House of Representatives and

Senate President

January 1, 2019

MSDHS Public Safety Commission Report

- Executive Summary:
- Chapter 1: Incident Overview and Commission Scope
- Chapter 2: Review of K-12 Active Assailant Incidents
- Chapter 3: Incident Timeline

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Chapter 4: MSDHS Overview, Security and Staff Response to the Shooting

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4.1 Physical Security Findings
Campus Physical Security (page 32)

1. Cruz arrived at MSDHS on February 14, 2018 at approximately 2:19 p.m. in an Uber that dropped him off on Pine Island Road to the east of the building 12. Cruz entered the MSDHS campus through an open and unstaffed pedestrian gate that had been opened by Campus Monitor Andrew Medina for afternoon dismissal. Cruz exploited this open and unstaffed gate and it is what allowed him initial access to the campus. This open and unstaffed gate was a security failure.

Campus Physical Security (pg. 32)

2. Unlocked and opened gates were regularly left unstaffed for long periods of time on the MSDHS campus. School administrators cited a lack of personnel as the explanation for the unstaffed and open gates. This explanation is unacceptable as leaving open perimeter gates unstaffed is a breach of effective security protocols.

3. The overall lack of uniform and mandated physical site security requirements resulted in voids that allowed Cruz initial access to MSDHS and is a system failure.

4.1 Physical Security Findings
Building 12 Physical Security and Warning Systems (pg. 37)

1. Cruz entered building 12 through the east unlocked door. This unlocked and unstaffed door allowed Cruz access to building 12 and is a security failure.

2. All of the classroom doors in building 12 could only be locked from the exterior. Teachers inconsistently locked classroom doors and some doors were unlocked the day of the shooting. Teachers were reluctant to enter the halls to lock the doors.

3. The fire alarm activated either because a beam of light was disrupted by the muzzle flash, smoke from the gun and/or dust created by the ceiling tiles moving from the percussion of the gunshots. No pull stations were triggered or pulled anywhere on campus.

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Building 12 Physical Security and Warning Systems (pg. 37)

4. Exterior video cameras were inadequate to cover the exterior of building 12 and other areas of the Stoneman Douglas campus.

5. Most school personnel were inadequately trained in how to operate the MSDHS camera system. This lack of familiarity and training adversely affected law enforcement response.

6. The school district does not allow Broward County law enforcement live, real time access to its school camera systems. Law enforcement's inability to live-view cameras in the building 12 hindered the law enforcement response and caused officer safety issues because law enforcement was unable to determine whether Cruz had departed the building.

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Building 12 Physical Security and Warning Systems (pg. 37-38)

7. There were no PA system speakers in the school building hallways and exterior areas, which prevented effective use of the school's intercom system to communicate the Code Red and provide directions to students and staff. The lack of an effective communication system prevents building occupants from effecting an active assailant response and moving to a place of safety; this is a breach of effective school safety best practices.
8. The fire alarm caused confusion among students and staff in building 12. Some treated the event as a fire alarm (evacuation) and some treated it as an active shooter situation (hiding in place). As set forth in section 5.2, the lack of a called Code Red contributed to students and staff not treating this incident as an active shooter event and that put students and staff at risk because they used evacuation protocols, not active assailant response protocols.

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Building 12 Physical Security and Warning Systems (pg. 38)

9. The glass windows in the classroom doors allowed Cruz line of sight access to target his victims and there were no pre-designated window coverings for teachers to quickly cover their classroom door windows.

10. Only 2 of the 30 classrooms in the building 12 had marked hard corners. To the extent that students attempted to hide in the classrooms' hard corners they were mostly inaccessible due to teachers' desks and other furniture occupying the space. There was inadequate space in many classrooms' hard corners and some students were squeezed out of the hard corners. Because classrooms lacked effective hard corners and/or students were not directed to hard corners, some students were forced to seek cover in an area visible to Cruz.

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Building 12 Physical Security and Warning Systems (pg. 38)

10. (Cont.) Cruz only shot people within his line of sight and he never entered any classroom. Some students were shot and killed in classrooms with obstructed and inaccessible hard corners as they remained in Cruz's line of sight from outside the classroom. The District's failure to mandate and implement hard corners or safe areas in every classroom was a safety breach that contributed to students being shot.

11. Some teachers said that they could use the PA to contact the front office, but did not want to risk harm making their way to the PA button. The classrooms lacked effective two-way communication systems (very few school personnel had school issued radios).

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Building 12 Physical Security and Warning Systems (pg. 39)

12. Some bullets traveled through the drywall and the metal doors. Had Cruz intentionally shot through the walls or doors, the amount of casualties could have been greater. Drywall and easily penetrable doors are a safety vulnerability.

13. The storm resistant glass on the third floor teacher's lounge mitigated the number of people shot because the rounds fragmented and prevented Cruz from effecting his sniper position. Despite trying to shoot from his sniper position, Cruz had 180 rounds of ammunition left when he abandoned his gun and fled the school.

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4.2 BCPS and MSDHS Active Assailant Response Policies and Training (pg. 40)

1. The lack of a formal Code Red or similar active assailant response policy in the Broward County Public Schools led to school personnel not knowing or clearly understanding the criteria for calling a Code Red, who could call it, or when it could be called. The lack of a called Code Red on February 14, 2018, because there was no policy, little training and no drills, left students and staff vulnerable to being shot, and some were shot because they were not notified to lockdown. This was most evident on the third floor of building 12.

2. BCPS now trains on active assailant response and conducts regular drills but the District still does not have a formal, written and disseminated Code Red policy.

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4.2 Assailant Response Policies and Training (pg.41)

3. Even after the hour long emergency code training with Al Butler in January 2018, teachers and MSDHS staff were still unsure as to the correct procedure required to call a Code Red and who could call a Code Red. As recently as late fall of 2018 during interviews of current MSDHS teachers and other staff they are still unclear as to who can call a Code Red and under what circumstances.

4. There were no Code Red drills at MSDHS in the year preceding the shooting.

5. Multiple teachers stated that Butler's training in January 2018 was useful because they did not have any prior Code Red training.

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4.2 Assailant Response Policies and Training (pg. 41)

5. (Cont.) After the training, administrators and campus monitors found most of the teachers locked their classroom doors. However, administrators and campus monitors did continue to find some doors around the campus unlocked and even propped open. These teachers were reminded to keep the doors shut and locked.

6. All teachers in building 12 who sheltered in place did so because the first thing they heard was gunfire, not because they were notified of an active shooter on campus, this is especially true on the second floor.

7. All teachers in building 12 who evacuated their classrooms did so because the first thing they heard was the fire alarm and had not been notified of a Code Red.

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4.2 Assailant Response Policies and Training (pg. 41)

8. Not one teacher in building 12 stated that they heard the Code Red being called over the PA. The teachers reacted to the sound of gunfire or the fire alarm. (The Code Red announcement over the PA was not made until Cruz had finished shooting all his victims and was entering the third floor teacher's lounge, which was too late to meaningfully notify anyone).

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4.3 School Administration and Security Staff Response on February 14, 2018 (pg. 71)

1. Campus Monitor Elliott Bonner called the first Code Red at MSDHS on February 14, 2018. This occurred at 2:24:54, 3 minutes 16 seconds after Cruz fired the first shots, and while Cruz was approximately half way down the third floor hallway shooting students. While there are other staff members who claim to have called a Code Red, there is no evidence to support those claims.

2. Campus Monitor Andrew Medina was the first school employee to observe Cruz walk onto the MSD campus. Medina saw Cruz carrying a bag that was obviously a rifle bag…

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4.3 School Administration and Security Staff Response (pg. 71-71)

2. (Cont.)—Medina admitted on video that he recognized the bag Cruz was carrying was a rifle bag and Medina identified Cruz as a threat. Medina failed to act appropriately by not calling a Code Red and that failure allowed Cruz to enter the 1200 building without the building's occupants being notified to implement an active assailant response (Code Red). Further, even after hearing gunshots Medina failed to call a Code Red. There are veracity issues with Medina's post-incident statements regarding what he knew and what he did and did not do.

3. After student Chris McKenna informed Coach Aaron Feiss that Cruz was in the 1200 building with a rifle, Feiss proceeded to the 1200 building but Feiss, who had a school radio, did not call a Code Red.

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4.3 School Administration and Security Staff Response (pg. 72)

4. Medina notified Campus Monitor David Taylor via school radio that Cruz was entering the 1200 Building. Taylor saw Cruz enter the building but Taylor did not call a Code Red. Taylor was inexperienced with guns and recognized Cruz when he entered the 1200 building as someone they had previously discussed as being a potential school shooter. Taylor's inaction by not calling a Code Red was inappropriate and delayed notification to others of the active shooting.

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Ch. 4 Recommendations

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Ch. 4 Recommendations (pg. 73)

- More funding is needed to ensure adequate school security and prevention measures, but cost will always be a factor in school hardening decisions; therefore, districts need to establish priorities.
- It is recommended that districts implement a tiered approach to campus hardening that begins with basic harm mitigation concepts that are of little or no cost and those that may be implemented quickly.
- After basic concepts have been implemented, districts should then consider more advanced security measures, specifically those focusing on prevention and those that involve technology and/or law changes. Tables 1 through 4 in Appendix B provide a suggested level—based approach to enhancing campus site security.

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Ch. 4 Recommendations (pg. 73)

- The OSS should also conduct a complete review of target hardening practices currently or planning to be utilized, recommendations highlighted in other state's school safety reports, and those developed by organizations such as the Partner Alliance for Safer Schools.
- Prior to August 2019, the OSS, using this review, and information received from experts, should provide the districts with a tiered list of best practices that allows schools to develop a plan to enhance and phase in security levels over time as budgets and resources allow.
  - The list should be reviewed and revised annually as new technologies are identified.
  - This recommendation **does not** mean districts should wait to implement reactive harm mitigation policies, procedures or best practices, such as requiring hard corners or safe areas in every classroom in the state.

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Ch. 4.1 Recommendations (pg. 73-74)

- The legislature should also consider creating a permanent body such as the Connecticut School Safety Infrastructure Council to oversee physical site security of schools. The Connecticut legislature created this Council of subject matter experts to oversee school security infrastructure, provide consistency and ensure compliance with best practices.

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Ch. 4.1 Recommendations (pg. 74)

Based on the incident at MSDHS, the following harm mitigation recommendations should be **implemented immediately** across all Florida schools:

A. School security is the function of all school personnel and all staff should have clearly established roles and responsibilities that are outlined in a written policy and procedure manual provided to all personnel. The school security staff and/or "safety team" should regularly meet and train on proper protocols and procedures in emergency situations and coordinate with law enforcement.

B. All school campus gates must remain closed and locked and when opened for ingress and egress they should be staffed to prevent unauthorized campus access.

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Ch. 4.1 Recommendations (pg. 74)

C. All campus building doors and classrooms should remain locked during school hours and if they are open they should be staffed. All teachers should be able to lock doors from within the classroom and keys should be on their person at all times.

D. Every district and school should have a written, unambiguous Code Red or similar active assailant response policy that is well known to all school personnel. The policy must make unequivocally clear that all personnel are empowered to activate emergency active assailant response procedures and that those procedures are to be immediately implemented upon notification.

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Ch. 4.1 Recommendations (pg. 74)

E. Every school must have an effective communication system through which everyone on campus can see and/or hear, and immediately react to, a called Code Red or similar active assailant response notification.

F. Classrooms should have established safety measures such as hard corners or other safe areas and teachers should have the ability to cover door windows quickly.

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Ch. 4.2 Recommendations (pg. 75)

- Every school district in Florida must have a well–developed, written, distributed, and trained upon active assailant response policy.
  - All school personnel must be held accountable for knowing and following the policy.
  - Regardless of what the policy is called (i.e. Code Red), it must unambiguously establish the roles, responsibilities and actions of all persons on campus to identify threats, notify others of threats and respond to threats.
  - The policy should be at the district level and each school should have an additional school-specific policy that addresses the idiosyncrasies and unique characteristics of each school and its population.

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Ch. 4.2 Recommendations (pg. 75)

- There should be sanctions for districts and schools that do not have implemented written policies by a specified date. The DOE Office of Safe Schools should be required to approve each district's policy and each superintendent should be required to approve each school's policy. In the case of a charter school the policy should be approved by its board of directors.

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Ch. 4.3 Recommendations (pg. 76)

- Campus monitors or their equivalent are common in Florida schools. Monitors are a cost-effective security supplement to SROs; however, monitors must be carefully selected, have clearly defined roles and responsibilities and be well trained.

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APPENDIX B. TARGET HARDENING

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Level 1 Recommendations

Policies and practices that can be implemented quickly and require little or no funding

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Campus Access (Public)

- Campuses should have single ingress and egress points to the extent that is consistent with this level's criteria of minimal cost. (If cost is significant then it should be considered later in the hardening process).
- Interior access should be limited by co-locating Attendance, Guidance, Main Office and other public business offices. (many schools have these functions spread throughout multiple locations on campus)
- Clear signs should direct visitors to appropriate entry points. All entry/exit doors should indicate a closed campus and direct visitors to report to the front office.

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Campus Access (Public)

- Non-essential visitors should be limited and when allowing visitors they should be required. to show positive identification, state their purpose for entering the school, be issued a visitor badge and have staff escort during the entire time the person is inside the school.
- Visitor management. All campus perimeter ingress and egress points shall be staffed when opened for student arrival and dismissal.
- Each school should have a written campus access policy that is distributed to all personnel.
- All staff and students should be required to wear school issued badges/identification
- Staff members should be trained to confront, if appropriate, or report anyone unauthorized to be on campus or any vehicle not parked in an authorized area.

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Campus Buildings (First Responders)

- Ensure all campus buildings are clearly marked with easily identifiable markings known to first responders. Mark first floor classroom windows so first responders can identify classrooms from the exterior.
- Building numbers should also be on the roof for aerial support.
- Provide keys/access to on duty law enforcement so they can quickly enter the school.

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Campus Monitoring

- All school districts should allow law enforcement at its discretion to live monitor all existing camera systems at all schools within the district.

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Building Exterior Doors

- There should be locks on all exterior/classroom doors and other areas where students assemble in mass (cafeterias, libraries, auditoriums). All doors should self-close and lock upon closing.

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Interior Classroom Doors/Windows

- All classroom doors should be able to be locked from inside or there must be an enforced policy that all doors remain locked at all times without exception.
- Classroom doors should either have no windows or every door should be equipped with a device that can readily block line of sight through the window
- First floor outside windows should be able to be blocked from line of sight.
- Policies should include that doors be checked regularly throughout the school day to ensure they are secure.

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Communication

- There should be effective two-way communications between lockdown spaces and school administrators, SRO or law enforcement.
- Schools should implement policies prohibiting students and staff from wearing any type of headphones or ear buds that prevent them from hearing emergency warnings and instructions. If earbuds are allowed it is recommended that students be allowed to only have one and not two at that same time.

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Accountability

- There should be consequences for not following safety and security measures in place (Students Code of Conduct, Employee Handbook, School Board Policy).

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Level 2 Recommendations:

May Require some low to moderate funding and a moderate implementation

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Ingress/Egress

- Fenced campuses with single ingress and egress points (could be a level III based on campus size and complexity). All fencing should be anchored to the ground and high enough to prevent easy climbing.
- Use protective bollards at campus entrances

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Communications

- There should be redundant two-way communications systems in every classroom and student assembly area. All interior building hallways and exterior common areas where students or staff move about should be equipped with speakers tied to the school's intercom system. This includes portable classrooms. Two-way communication systems are preferred but at least one-way notification systems are paramount.
- All school radio traffic should be recorded

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Common Areas (Locks)

- All common use closed areas in a school should have electronically controlled doors that can be locked remotely or locally with appropriate hardware on single and double doors to resist forced entry.
- Install door sensors and cameras on all doors vulnerable to unauthorized access use by students and staff to ensure all doors are locked at all times.

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Video Coverage

- Enhance current video surveillance systems to eliminate any interior/exterior gaps in camera coverage including front door access control.
- Consider video surveillance systems capable of internet access that include first responder and emergency communications centers access via the internet during an emergency.

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Funding for High Tech Infrastructure

- DOE should ensure that each of the districts are fully aware and partaking in the E-rate program (also referred to as Schools and Libraries program) to fund and utilize current high speed broadband as it relates to school security i.e. enhancing camera and audio capability as technology is being implemented.

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Level 3 Recommendations:

May require moderate to significant funding, but no law or regulation changes
and moderate to long term implementation

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Doors/Windows (Some mentioned in Level II)

- Install electronically controlled door systems.
- Install ballistic resistant glass covering on classroom door windows and first floor classroom exterior windows.
- Install door alert systems that can be monitored from a central location to determine if a door is closed or propped open.
- Install classroom door windows that are small enough to restrict access and located a sufficient distance from the door handle to prevent a person from reaching through to unlock the door from the interior.

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Parking and Bus Lots

- All parking areas should be outside of the single point of entry perimeter.
- Ensure that there is adequate lighting that allows for clear observation of all entry points and parking lots.
- Bus loading and unloading areas should have physical separation from visitor parking, parent drop off and walkers.
- Install GPS locators on all school buses

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During a Lockdown

- If a Code Red or other active assailant response is initiated, make sure that message is displayed on all computer screens connected to the school's computer network.
- Establish a system that notifies staff, district officials, parents and students off campus by email, text, and/or phone about an active assailant response being implemented.

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Level 4 Recommendations:

May require significant funding and/or changes in laws or regulations and long term/multi-year implementation

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High Tech/High Expense

- Consider the use of metal detectors and x-ray machines at campus entrances.
- Implement real time crime centers or their equivalent with live video monitoring capability of all cameras on all school campuses.
- Gunshot location sensor should be tied into camera system
- Use tactical tablets that are directly fed to the E911 system.
- RFID and Near field communications (NFC) card readers should replace all door locks on campus.
- Install electronic message board in every classroom

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High Tech/High Expense

- New buildings or major renovations must include sensors that alert the office staff when exterior doors are not secured with electronic monitoring that automates the process of identifying the cause of the open door.
- Have the legislature mandate and pay for ballistic glass on all interior and exterior school windows by the year 2025.
- Shipping and receiving areas should be designed to allow access without breaching the single point of entry containment system and have electronic monitoring.
- Add capital funding for school building construction to allow for the removal of portable classrooms
- Interior corridors between classrooms should have the ability to electronically seal the movement of intruders but allow staff to move easily with electronic access control.

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Other

Stop the Bleed Program

- Faculty should be trained in "Stop the Bleed" procedures with adequate kits for all schools.
- This should be covered in First Aid Training with adequately trained school personnel.

Biometrics

- The current Florida statute that restricts the use of biometrics (e.g. face recognition) for
- use in student records should be rescinded or altered to permit and/or encourage use of biometrics capabilities to be employed in school security systems such as access control and visitor management.

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Ch. 5: On Campus School Resource Officer Response

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5.1 Deputy Scot Peterson's Actions on February 14, 2018 (pg. 77)

1. Former Deputy Scot Peterson was derelict in his duty on February 14, 2018, failed to act consistent with his training and fled to a position of personal safety while Cruz shot and killed MSDHS students and staff. Peterson was in a position to engage Cruz and mitigate further harm to others and he willfully decided not to do so.

2. There is overwhelming evidence that Deputy Peterson knew that the gunshots were coming from within or within the immediate area of building 12. Furthermore, there is no evidence to suggest that Peterson attempted to investigate the source of the gunshots. In fact, the statement of Security Specialist Greenleaf confirms Peterson did not attempt to identify the source of the gunshots and by all accounts – including surveillance video - Peterson retreated to an area of safety.

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5.1 Deputy Scot Peterson's Actions on February 14, 2018 (pg. 86)

3. Confusion in identifying the source of gunshots due to echoes around the structures was eliminated as an excuse for Peterson not entering building 12 due an abundance of evidence including, but not limited to:

- Peterson had been told by Medina that the noises were coming from within building 12.
- Peterson was dropped off at the doors to building 12.
- Peterson repeatedly referenced building 12 on his BSO radio.
- Peterson told Officer Best that the shooter was on the second or third floor
- In his BSO interview, Peterson identified the gunshots as coming from within or in the immediate area of building 12.

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5.1 Deputy Scot Peterson's Actions on February 14, 2018 (pg.87)

4. On February 14th, the BSO law enforcement response to MSDHS was hindered in part by MSDHS School Resource Officer Scot Peterson's erroneous directions and other improper information he relayed over BSO's main radio channel 8A to include, directing responding deputies to shut down nearby intersections and requesting no pedestrian traffic anywhere on nearby roads.

5. Peterson instructed deputies to stay at least 500 feet away from the 12 or 1300 buildings. These instructions conflict with current law enforcement response procedures to active shooter situations. Law enforcement officers should try to eliminate any immediate threat even if that requires approaching gunfire and danger.

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5.1 Deputy Scot Peterson's Actions on February 14, 2018 (pg. 87)

6. Deputy Peterson responded to the area of building 12 within approximately 1 minute 39 seconds after the first shots were fired. Prior to his arrival 21 victims had already been shot, 9 of which were fatally wounded. This makes clear that seconds matter and that SRO's cannot be relied upon as the only protection for schools. Even if there is a rapid response by an SRO, it is insufficient in and of itself to safeguard students and teachers.

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Ch. 5.2 Deputy Peterson's Training (pg. 87)

1. BSO trained Deputy Peterson on active shooter response and he was familiar with solo deputy response protocols. Peterson knew through his training that the appropriate response was to seek out the active shooter and not "containment." (Containment is the unaccepted practice of setting a perimiter and waiting for the shooter to exit the building or waiting for other deputies or SWAT to arrive before entering as a group.)

2. Peterson knew that an active shooter situation called for a Code Red response. Based on interviews conducted with MSD school personnel, Deputy Peterson never called out a Code Red over the school radio.

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5.2 Deputy Peterson's Training (pg. 89)

3. Deputy Peterson was an SRO for 28 years and that likely provided him a great deal of experience in some aspects of being an SRO, however, it also contributed to his inadequate response to this shooting.

4. SROs typically are not faced with many high-risk, high-stress situations such as domestic violence calls, robberies, shootings, etc. As a result, they are not afforded the chance to maintain and exercise their tactical skills other than in training scenarios. For that reason, it is of the utmost importance that SROs be provided with frequent, thorough and realistic training to handle high-risk, high stress situations.

5. At the time of the incident, Deputy Scot Peterson did not have a ballistic vest or a patrol rifle with him.

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Ch. 5.3 Broward County SRO Structure and Staffing Levels (pg. 89)

1. One SRO per campus is inadequate to ensure a timely and effective response to an active assailant situation and some campuses require additional armed personnel.

2. BSO's decentralized supervisory structure of its SRO program raises concerns about whether Peterson was adequately supervised.

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Ch. 5 Recommendations

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Ch. 5 Recommendations (pg. 90-91)

SRO Structure

- BSO and all law enforcement agencies should ensure their SROs are part of a single unit and that they are closely supervised. A single unit and centralized supervisory structure provides SRO supervisors the ability to effectively communicate with and evaluate the officers and deputies at the various schools.
- It should be made clear to all stakeholders that the primary responsibilities of the SRO shall be the enforcement of the laws and the safety and security of the campus, students and school personnel. The SRO may still have teaching and counseling duties, but these are secondary to that of safety and security.

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Ch. 5 Recommendations (pg. 91)

SRO Structure

- SRO contracts between the law enforcement agencies and school boards should require a high level of information sharing between the SRO and school administrators. The contract should also state that: 1) the SRO or applicable law enforcement agency shall have access to educational / disciplinary records provided by the school; 2) decisions regarding law enforcement actions are solely within the discretion of law enforcement officers and that school administrators shall not interfere with law enforcement decisions; and 3) have consistent operating procedures, staffing levels and clearly defined roles and responsibilities for the SRO and school personnel.
- All SRO's should be issued patrol rifles and ballistic vests and have those items immediately available to them on school campuses.

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Ch. 5 Recommendations (pg. 91)

SRO

- School Resource Officers (SRO's) should be among the most well-trained and well-equipped law enforcement personnel to confront active-shooters. In order to do so, SRO's should receive additional training in this area.
- The SRO's immediate supervisor should regularly walk the school with each SRO to discuss the lay out of the school, identify vulnerable target areas and effective methods of response.

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Ch. 5 Recommendations (pg. 91)

SRO

- SROs should receive adequate training on records laws and there should be a required number of hours focusing on trauma informed care, socio-emotional learning, restorative justice problem solving, and cultural competence.
- SROs should receive frequent, thorough and realistic training to handle high-risk, high stress situations, especially single officer response training.

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Ch. 5 Recommendations (pg. 92)

SRO/Guardian Ratio

- There shall be a minimum of at least one law enforcement officer on every middle and high school campus and a minimum of one law enforcement officer or Guardian on every elementary school campus.* Each allocation of law enforcement officer/Guardians should be staffed sufficiently to provide for an immediate backup and an appropriate and timely response consistent with the circumstances of an emergency situation.

*The DOE and Legislature should identify, define and enumerate what constitutes a public high school, middle school and elementary school, to exclude on-line, private, singular room specialty schools, and collegiate high schools, which already have college campus police providing security.

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Ch. 5 Recommendations (pg. 92)

SRO/Guardian Ratio

- A model for SRO staffing ratio is provided below. A point value would be used under this model to determine how many SROs and/or Guardians should be decided to a particular campus.

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Ch. 5 Recommendations (pg. 92)

Factors

1. School population to include staff and teachers
   - Less than 500
   - 500-1000
   - 1000-1500
   - 1500-2000
   - 2000-2500
   - 2500-3000
   - 3000-3500
   - More than 3500

2. School Design – Campus design
   - Single building
   - Multiple buildings (connected – closed walkways)
   - Multiple buildings (connected – open walkways)
   - Multiple buildings not connected
   - Distance between buildings

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Ch. 5 Recommendations (pg. 93)

3. School Design – Physical barriers
   - Campus perimeter fenced/walled
   - Single point access
   - Multiple point access
4. School Design – Security
   - Camera systems
     - Passive monitoring
     - Active monitoring-

   Personnel with continuous monitoring
   Personnel with intermittent monitoring
5. Proximity to other schools
6. School location
   - Urban
   - Suburban
   - Rural
7. Staff to student ratio:
   - 10:1
   - 15:1
   - 20:1
   - 25:1
8. Law Enforcement Officer or Guardian

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Ch. 5 Recommendations (pg. 94)

SRO and Guardian Funding

- The Florida Legislature should increase safe schools allocation for school resource officers and/or guardians, provide adequate recurring funding for the Guardian program and should consider increased funding for individuals who are hired solely to fill the role of Guardian; allow for the use of school safety funding between different categories based on need, and amend current version of SB7026 to allow for safe schools allocation to be used for new or existing school resource officers; and restore local authority to public school boards to levy up to a half mil without a referendum for law enforcement officers or Guardians, or other direct school security expenses.

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Ch. 6: Off Campus Law Enforcement Response

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Ch. 6.1 Off Campus Law Enforcement Response (pg. 155)

1. While several deputies have been identified as not properly responding to hearing gunshots, many other deputies responded in the proper manner by running to the scene, seeking out the shooter, providing medical aid and evacuating victims.

2. The sporadic functioning of BSO's radios undoubtedly hindered BSO's response. To an unknown extent, the school structure itself also hindered the radio functionality.

3. Several uniformed BSO deputies were either seen on camera or described taking the time to retrieve and put on their ballistic vests, sometimes in excess of one minute and in response to hearing gunshots.

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6.1 Off Campus Law Enforcement Response (pg.156)

3. Deputy sheriffs who took the time to retrieve vests from containers in their cruisers, removed certain equipment they were wearing so that they could put on their vests, and then replaced the equipment they had removed all while shots were being fired, or had been recently fired is unacceptable and contrary to accepted protocol under which the deputies should have immediately moved towards the gunshots to confront the shooter.

4. Several BSO deputies arrived on Holmberg Road, just north of building 12 while shots were being fired and most of them heard the shots. These deputies have been identified as Kratz, Eason, Stambaugh, Perry, Seward, and Goolsby. These deputies remained on Holmberg road and did not immediately move towards the gunshots to confront the shooter. The deputies' actions appear to be a violation of accepted protocol under which the deputies should have immediately moved towards the gunshots.

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6.1 Off Campus Law Enforcement Response (pg.156)

5. Law enforcement officers within building 12 became confused over which rooms had been cleared and which rooms had not been cleared. BSO SWAT used a color-coded glow stick method to mark certain rooms but the inherent short coming in that system is that the glow sticks can easily be kicked out of place. BSO needs a more effective system for its SWAT Team to denote cleared room than glow sticks.

6. City officials, school board members, county commissioners, and other politicians were unnecessarily present at the command post in the early stages of the response. Their presence interfered with command and control operations.

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6.1 Off Campus Law Enforcement Response (pg.156)

7. There was abundant confusion over the location of the command post and the role of the staging area. This stemmed from an absence of command and control and an ineffective radio system.

8. A unified command consisting of command staff from BSO, CSPD, and CSFD took an excessive amount of time to establish.

9. While not law enforcement's fault, the school's staff lacked adequate ability to operate the camera playback system. The fact that law enforcement erroneously believed for a considerable amount of time that Cruz was still in the building and was being watched on camera misled officers and deputies and adversely affected their decision-making and victim rescue efforts.

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6.1 Off Campus Law Enforcement Response (pg.157)

10. The Broward County Public School's decision not to allow law enforcement live and real time direct access to the school camera systems in Broward County, including the system at MSDHS, adversely affected law enforcement efforts to locate Cruz and it hampered victim rescue efforts.

11. Coral Springs Police officers consistently praised their training as preparing them for a proper response. Without hesitation, each officer knew the active shooter training they had received annually for the past several years. They had no difficulty in identifying the proper response to an active shooter.

75

6.1 Off Campus Law Enforcement Response (pg.157)

12. On the other hand, Broward Sheriff's Office deputies remembered that they attended training in the past few years, but some could not remember the last time they attended active shooter training. Some BSO deputies could not even recall the type of training they received. Several were specific in referencing that their policy says deputies "may" go toward the shooter.

13. A significant number of officers and deputies said that additional training would be beneficial; however, they also said that no amount of training can prepare you to face such an event.

76

6.2 Incident Command and Control (pg. 185)

1. Sergeant Miller was the first responding supervisor and he arrived on Holmberg Road at least by 2:27:03. By his own statements he heard 3 to 4 shots upon arrival. Miller was not wearing his ballistic vest and took time to put it on. Miller was on scene for approximately 7 minutes before BSO's radio throttling began; therefore, radio capacity issues did not exist at the time of Miller's arrival. Miller failed to coordinate or direct deputies' actions and did not direct or coordinate an immediate response into the school. Miller was observed behind his car on Holmberg Road and he did not initiate any radio transmissions until approximately 10 minutes after arriving on scene. Sergeant Miller's actions were ineffective and he did not properly supervise the scene.

77

6.2 Incident Command and Control (pg. 185)

2. Captain Jordan failed to timely establish an incident command and was ineffective is her duties as the initial incident commander. While Capt. Jordan experienced radio problems that hindered her ability to transmit, nobody reported receiving command and control directions from Jordan in person. Jordan spent approximately the first 7 minutes after her arrival in the building 1 office and then transitioned to a position of cover in the north parking lot behind a car with Deputy Perry.

78

6.2 Incident Command and Control (pg. 185)

3. There was confusion over the location of the command post, staging area, and TOC. After taking over as the incident commander, Colonel Polan remained at the TOC and was not present at the command post. Colonel Polan's absence at the CP confused others as to who was the incident commander.

4. The law enforcement command post and fire department command post were separate and they should have been unified.

79

6.3 Active Assailant Response Policies & Training BSO & CSPD (pg. 188)

1. BSO deputies had some level of knowledge and familiarity with their active shooter policy. Several of them referenced that their policy states that they "may" enter a building or structure to engage an active shooter.

2. The use of the word "may" in the BSO policy is ambiguous and does not unequivocally convey the expectation that deputies are expected to immediately enter an active assailant scene where gun fire is active and neutralize the threat.

3. Some deputies could not remember the last time they attended active shooter training.

80

6.3 Active Assailant Response Policies & Training BSO & CSPD (pg. 188)

4. Some deputies could not recall what type of training they received.
5. CSPD officers had a high level of knowledge and familiarity with their active shooter policy. Many reference that the policy sates they "shall" engage the threat.
6. All CSPD officers remembered their active shooter training because they attend the training on an annual basis. Many of the officers praised the quality of their training and the equipment which they are provided.

81

Ch. 6 Recommendations

82

Ch. 6 Recommendations (pg. 188)

- The Broward County Sheriff should conduct an internal review into the conduct of deputies Kratz, Eason, Stambaugh, Perry, Seward, Goolsby and Sgt. Miller. If there is cause to believe their actions violated agency policy the Sheriff should conduct a formal internal affairs investigation and take action he deems appropriate.
- The Broward County Public Schools should immediately provide law enforcement with live and real time access to all school camera systems.
- All Broward County law enforcement and fire/EMS agencies should establish protocols for a unified command at all MCI or similar incidents. Every Florida county should be required to have a major incident unified command inter-local agreement that establishes the protocols for a unified command structure.

83

Ch. 6 Recommendations (pg. 189)

- The incident commander should be present at the command post and not at the TOC to avoid confusion as to who is in charge and effectively participate in a unified command.
- A staging area outside the command post should be standard protocol for meeting arriving elected officials.
- BSO should revise its active assailant policy to make unequivocally clear that deputies are expected to immediately seek out an active assailant and that "containment" is not the policy of BSO.

84

Ch. 6 Recommendations (pg. 189)

- BSO should enhance its active assailant training. With the number of deputies who cannot recall the training or recall the last time they attended it does not seem to be resonating with deputies, especially those who responded to MSDHS.
- CJSTC and individual law enforcement agencies are encouraged to require single officer response to active assailant training.

85

Ch. 7: Fire Department/EMS Response & Victims' Emergency Medical Treatment

86

Ch.7.3 Medical Response Timeline within Building 12 (pg.197)

1. There is no evidence that any victims at MSDHS did not receive appropriate medical care.

2. There is no evidence that law enforcement commander's decision to not authorize rescue taskforces affected anyone from receiving appropriate and timely medical care. Rescue taskforces are only appropriate to operate in the "warm zone," and not the "hot zone"; the building 12 was a "hot zone." The decision not to use RTFs at MSDHS was the correct decision.

87

7.3 Medical Response Timeline within Building 12 (pg. 198)

3. There is no evidence that any medical personnel (doctors, etc.) who arrived at the scene were inappropriately denied access to the building 12 to provide medical care or that victims were not timely and appropriately removed so they could receive medical care.

4. The TAC-medics followed the standard procedures of a MCI to identify, assess and tag the patients within building 12.

5. The first responding law enforcement officers acted appropriately and consistent with their training when they first removed victims who were verbal and/or conscious during the initial 7 to 14 minutes.

88

7.3 Medical Response Timeline within Building 12 (pg. 198)

6. The lack of a clearly identified Command Post (CP) and BSO command personnel being split between the CP area and the Tactical Operations Center (TOC), impeded communication with fire department command staff.

7. Radio communication problems, including the lack of interoperability and throttling affected the tactical operations inside of building 12, including the medical response.

8. The FLPD medics who self-deployed into building 12 without dispatch or briefing, should not have entered the building without approval. The officer at the door did not direct the medics to a BSO medic or brief them on conditions. The officer at the door should not have allowed these medics into the building 12 without authorization.

89

7.3 Medical Response Timeline within Building 12 (pg. 198)

8. (cont.) These self-deployed medics conducted their assessments not seeing or ignoring the black tags on the victims' arms and legs identifying them as deceased. These medics entered the building and conducted their patient assessments well over one hour after the first emergency personnel entered the building 12.

9. The FLPD medics claim of "feeling a pulse" on Montalto was medically incorrect. The removal of this patient was unnecessary and created a false perception that medical care was not provided in a timely manner.

90

Ch. 7 Recommendations

Ch. 7 Recommendations (pg. 198)

- Law enforcement and fire departments in each county should have established agreements governing self-deployment and establishing response protocols to avoid inappropriate deployments. Self-deployment is going to occur due to any significant event and it must be managed.
- Law enforcement agencies are encouraged to formalize Rescue Task Force protocols with fire/EMS agencies and to train with them on a regular basis.
- Fire and EMS providers must be part of the unified command at any MCI or other significant event and fire/EMS should not have a separate command post from law enforcement.

Ch. 8 Incident Interoperability Law Enforcement 911, Radio, & Computer Aided Dispatch (CAD) Systems

93

Ch. 8.2 911 System (pg. 207)

1. The 911 system on February 14, 2018, and the current 911 system in Parkland that has all Parkland 911 calls from cellular phones routed to Coral Springs, hinders a swift and effective police response by BSO. All Parkland 911 callers from cell phones who need police assistance have to explain their emergency to the Coral Springs dispatcher who then tells the person to standby while Coral Springs calls Broward County Regional Communications. The Coral Springs dispatcher then tells the BSO dispatcher that they have a caller on the line with a police emergency and the 911 caller repeats the reason for needing the police all over again to the BSO dispatcher.

94

Ch. 8.2 911 System (pg. 207)

1. (Cont.) In many instances the original 911 caller hangs up before being transferred to BSO by Coral Springs and this hinders the BSO dispatcher because they are unable to speak directly to the caller needing police help in Parkland. This also creates an officer safety issue for Parkland deputies because they cannot obtain updated information while responding to the emergency because the caller hung up and the dispatcher cannot reestablish contact with the caller. Many callers also become frustrated because they have to explain their emergency a second time and they do not understand the necessity of the redundancy.

   This call transfer system prohibits BSO from receiving direct 911 calls from its service area in Parkland and creates a situation, as it did on February 14, 2018, where there is an information void adversely affecting an effective law enforcement response.

95

Ch. 8.2 911 System (pg. 208)

2. The system is designed for Coral Springs to transfer all 911 law enforcement calls it receives from Parkland to BSO. On February 14, 2018, Coral Springs transferred very few calls it received and this resulted in BSO, as the primary response law enforcement agency, not knowing all the information known to Coral Springs. This hindered BSO's response.

3. On February 14, 2018 the Coral Springs 911 communications center initially treated the MSDHS shooting solely as a fire/EMS event because it provides fire and emergency medical services to Parkland, not police response. Coral Springs waited 4 minutes and 22 seconds from the time it received the first call of shots fired at MSDHS until it dispatched its first Coral Springs police officer. Coral Springs could not effect a quicker response by BSO because it had to transfer the call to BSO and Coral Springs could not directly communicate via radio with BSO Parkland deputies.

96

Ch. 8.2 911 System (pg. 208)

4. The decision to route all Parkland 911 calls that originate from cell phones to Coral Springs and not Broward Regional Communications (BSO) was made by the City of Parkland. The call transfer process delayed the law enforcement response to MSDHS on February 14, 2018. The City of Parkland has the authority to decide where its 911 calls are routed and the City can change the routing process at-will.

5. BSO brought the Parkland 911 call workflow issues to the City of Parkland in 2014 but there have no discussions resulting in a resolution since that time.

97

8.3 Law Enforcement Computer Aided Dispatch Systems (CAD) (pg. 210)

1. Coral Springs and BSO have independent CAD systems so officers and deputies cannot see each other's calls in addition to not being able to hear each other's calls on the radio. There is no electronic data sharing of CAD data between Coral Springs and BSO.

2. There are no known substantive issues regarding the actual entries made into the BSO or CSPD CAD systems on February 14, 2018, other than CSPD and BSO officers and deputies could not view each other's CAD data.

98

8.3 Law Enforcement Computer Aided Dispatch Systems (CAD) (pg. 210)

3. The initial CAD entry into the Coral Springs Fire Department CAD and not the Coral Springs Police Department CAD delayed the law enforcement response.

4. Different law enforcement agencies using different CAD systems within the same county creates information silos and barriers to sharing emergency information as well as delaying response to emergency calls.

8.4 Law Enforcement Radio Systems (pg. 213)

1. Due to the independent communications systems of BSO and Coral Springs the agencies do not share a radio channel. On February 14, 2018, neither CSPD nor BSO patrol units had each other's radio channels in their portable radios. Further, BSO dispatch did not have the CSPD radio channel in its dispatch console. CSPD recently authorized BSO to install its radio channel in its dispatch consoles and BSO Parkland deputies now have CSPD radio channels in their portable radios.

2. The lack of radio interoperability and the BSO throttling issue hampered the response and caused officer safety issues. The BSO system currently in use can only accept about 250 inbound requests per minute, whereas the new system that will be implemented at the end of 2019 will have a much higher capacity reaching about 750 inbound requests per minute.

8.4 Law Enforcement Radio Systems (pg. 214)

3. BSO and CSPD not being able to communicate on the same radio channel or through patched channels affected the law enforcement response and caused information voids and silos. A patch was attempted on February 14, 2018 and it failed because BSO did not have CSPD's channel in its dispatch console. BSO could not patch what it did not have.

4. While there existed common mutual aid channels that officers and deputies could have used there was inadequate common knowledge that the channels existed and personnel were not trained in how to easily access the channels. Moreover, it would have been cumbersome, impractical and tactically unsound to go through the process of switching to a mutual-aid channel while actively responding to the MSDHS shooting.

101

8.4 Law Enforcement Radio Systems (pg. 214)

5. The lack of capacity caused radio "throttling" during BSO's response to the MSDHS shooting and resulted in BSO deputies and command staff not being able to transmit on their radios. The BSO radio throttling also hampered effective command and control.

6. Because BSO SWAT could not effectively communicate via radio, SWAT had to use cell phones and "runners" to communicate in-person due to the radio failures.

7. The same radio problems also happened during BSO's response to the Ft. Lauderdale Airport shooting in 2017.

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8.4 Law Enforcement Radio Systems (pg. 214)

8. Coral Springs has expressed concern over the county's radio replacement plan and has no plans to join the regional communications system even when the new radio system is in place.

9. CSPD radios are equipped with GPS so that Coral Springs communications center knows the precise location of every officer all the time. BSO does not have this technology and their ability to know the precise locations of deputies is limited.

Ch. 8 Recommendations

Ch. 8 Recommendations (pg. 215)

- Law enforcement agencies should be required to have communications interoperability with all other law enforcement agencies in their county. The methodology for accomplishing this is immaterial, but the interoperability is essential.
- If an agency asks another agency for access to their radio channels it should be mandated that the agency honor the request.
- Law enforcement agencies are encouraged to tactically train their personnel so they are familiar with all radio functionality.
- Florida law should require that all primary 911 call centers have the ability to directly communicate via radio with the first responder units for which they are receiving 911 calls.

105

Ch. 8 Recommendations (pg. 215)

- All public safety agencies should work toward consolidation of 911 call centers and eliminate the 911call transfer process.
- The City of Parkland should require that Broward County Regional Communications receive all cellular and landline 911 calls originating in the city of Parkland.
- School districts and law enforcement agencies should strive for radio interoperability
- All law enforcement agencies in Broward County, and every county in Florida, should operate on a single computer aided dispatch (CAD) system.

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Ch. 9: Summary of Cruz's Life & Contacts Prior to February 14, 2018

Ch. 9 Summary of Cruz's Life & Contacts Prior to February 14, 2018 (pg. 250)

1. The majority of Cruz's contacts with BSO before the shooting did not involve criminal activity and most were initiated by Lynda Cruz because Nikolas and his brother were misbehaving or had runaway. Most of BSO's contact with Cruz and his family prior to the shooting did not warrant additional action other than what was taken in response to the call at the time.

2. At least 30 people had knowledge of Cruz's troubling behavior before the shooting that they did not report or it was not acted on by people to whom they reported their concerns.

Ch. 9 Summary of Cruz's Life & Contacts Prior to February 14, 2018 (pg. 251)

3. There are at least six people who stated that they brought concerns about Cruz and his behavior, including discussions about Cruz being a "school shooter" to MSDS Assistant Principal Jeff Morford. Morford denies every one of these reports or claims he does not recall the reports and/or discussions. Morford's veracity in denying knowledge or recollection of these incidents is questionable.

4. The FBI failed to appropriately process and respond to the information it received regarding Cruz. The FBI has taken remedial measures to rectify the flaws in its processes and system that allowed the failure to occur.

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Ch. 9 Summary of Cruz's Life & Contacts Prior to February 14, 2018 (pg. 251)

5. The Broward County Sheriff's Office failed to appropriately process and respond to the information it received regarding Cruz in November 2017, and it disciplined the deputy for not properly investigating the incident.

6. Cruz made several social media posts that raised concerns about his behavior. Like so many other situations, there were missed indicators of targeted violence by Cruz in these posts. Cruz had a widely known fascination with guns and the military and a history of animal abuse, which are all primary indicators of future violent behavior.

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Ch. 9 Summary of Cruz's Life & Contacts Prior to February 14, 2018 (pg. 251)

7. Whether at school behavior, behavior at home or acts toward his mother (mostly unreported) there were several missed opportunities to engage Cruz in the judicial system through arrest for various offenses. The offense were mostly minor but they were plentiful and by not arresting Cruz the judicial system did not have an opportunity to identify and address his systemic and troubling behavior.

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Ch. 9 Recommendations

112

Ch. 9 Recommendations (pg. 251)

- The Broward County Public Schools should conduct an internal investigation regarding Assistant Principal Jeff Morford to determine whether information was known and/or reported to him regarding Cruz that he should have acted on, and if he had that knowledge whether he violated any District policies. BCPS should take appropriate action it deems necessary as a result of its investigation.

113

Ch. 9 Recommendations (pg. 252)

- Schools should be required to notify students of FortifyFL and promote its use by advertising the app on campus and in school publications. Education about and publication of reporting platforms must be continuous and ongoing by the schools.
- Every school district should implement a policy that requires its personnel to report all indicators of suspicious student behavior to an administrator. The administrator should be required to document the report and his/her disposition of the information (i.e. referred to threat assessment team, unsubstantiated, etc.). The policy should require that the disposition of all threats of school violence be reviewed at least by the school's principal if not higher authority.

114

Ch. 10:Cruz's Services by Mental Health Providers

115

Ch. 10.1 Cruz's Services by Mental Health Providers (pg.256)

1. Cruz had several different public and private mental health providers. There was some care coordination, but no master case management. No one health professional or entity had the entire "story" regarding Cruz's mental health and family issues.

2. Cruz received extensive mental and behavioral health services until he turned 18 and decided himself to stop treatment.

3. By his own choice and because of his decision to stop treatment, Cruz was not under the care of any mental health provider at the time of the shooting. Cruz's last contact with HBH was 14 months before the shooting and his last known appointment with a psychiatrist was six months before the shooting.

116

Ch. 10.2 Baker Act (pg.259)

1. There is no evidence that Cruz ever met the criteria for involuntary examination under the Baker Act and an evaluation was not performed. There is no evidence that the Baker Act evaluation conducted on September 28, 2016 reached an improper determination that Cruz did not meet the criteria that day for an involuntary examination.

2. If Cruz was Baker Acted for an involuntary examination it would never have disqualified him from gun purchase, possession, or ownership rights under then-existing law or current law

Ch. 10 Recommendations

Ch. 10 Recommendations (pg. 260)

Mandatory Duty to Warn

- The legislature should amend F.S. 394.4615 and require that mental health providers release a clinical record and require that they warn others of threatened harm by a patient. Currently the duty to warn is permissive and warning is not required. The law should require that the provider notify law enforcement and law enforcement warn the person threatened as necessary to protect their safety.

School-Based Services

- To the extent permitted by law, including exceptions that generally prohibit the release of protected health information, private providers should share information with school-based providers and coordinate care.

Ch. 10 Recommendations (pg. 260)

School-Based Services (cont.)

- The sharing of information should be mandated when there is a threat of harm to school personnel and/or students.
- Schools should be required, as permitted, to share student mental health information with community-based providers.

School Mental Health Records

- School mental health and counseling records should be included in each student's school record and that record should accompany the student to each school they attend within the district, as well as follow the student if they switch districts.

Ch. 10 Recommendations (pg. 261)

Screening and Referral for Services

- The legislature should require by statute that any student referred for developmental delay and/or behavioral issue testing and screening be tested within 90 days of the referral, and that the student be provided a referral for resources and/or services within 30 days of the testing/screening if needed.

. **Case Management**

- Implement Targeted Case Management for children and young adults (ages 13 – 25) who are high utilizers of mental health services, who are receiving school and community based mental health services, and/or who have been identified as a potential threat in the school environment to improve information sharing and ensure coordination of services.
- Use a blended funding approach to SEDnet using school and community based behavioral health funding sources to facilitate cost sharing and improve information sharing and care coordination of school and community based intervention services

121

Ch. 11: Cruz's School Discipline & Juvenile Diversion

122

11.3 Promise Program (pg. 265)

1. Cruz's actions for which he was referred to PROMISE would have constituted a misdemeanor charge of vandalism or damage to property under $1000, or criminal mischief, as it is formally know under Florida law. Under PROMISE criteria, when a student commits a first time misdemeanor vandalism, the school administrator is not required to consult with law enforcement. However, a second or subsequent vandalism incident mandates consultation with law enforcement.

2. If Cruz had been referred to the juvenile justice system for not completing PROMISE, it is probable that he would have been referred to a Florida Department of Juvenile Justice (DJJ) diversion program for first time misdemeanor offenders. Alternatively, If Cruz had been arrested on November 25, 2013 for vandalism; he would have been transported to a juvenile booking center and immediately released to his mother, because Florida law would not have allowed DJJ to detain Cruz for this offence.

123

11.3 Promise Program (pg. 265)

2. (cont.) If the case had then been prosecuted by the state attorney's office, and he was adjudicated guilty, he would have likely received community service or a comparable sanction for this first time misdemeanor offense. Adjudication of guilt to a misdemeanor vandalism charge would have had no legal relevance on any subsequent contact Cruz had with law enforcement, and it would not have impacted Cruz's legal right to buy, own or possess a firearm.

3. The PROMISE program is largely consistent with Florida's civil citation criteria, which applies to youth who commit misdemeanor acts outside of school. A significant deviation is the "offense reset" every school year. Additionally, PROMISE data and a student's participation are not integrated with the Florida Department of Juvenile Justice (DJJ) Prevention Web tracking of civil citation juvenile pre-arrest diversion.

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11.3 Promise Program (pg. 266)

3. (cont.) Therefore, in Broward County, a juvenile could have multiple in-school PROMISE diversions and multiple out-of-school civil citation diversions, without either system being aware of the multiple diversions.

4. Under state law in effect prior to July 1, 2018, the state's civil citation pre-arrest diversion program allowed juveniles to participate in pre-arrest diversion up to three times. Current law allows the number of pre-arrest diversions to be set by the stakeholders in each of Florida's 20 judicial circuits.

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Ch. 11 Recommendations

126

Ch. 11 Recommendations (pg. 266)

All juvenile pre-arrest diversion programs, to include all school-based diversion programs that address criminal conduct, must be part of and operated consistently with the pre-arrest diversion program criteria established by the state attorney and other stakeholders in each judicial circuit. Any school-based diversion program must be defined in school policy and approved by the district School Board.

Criteria:
While each circuit has authority to establish criteria for diversion programs, circuits should consult with each other in an effort to create as much consistency statewide as possible. Program criteria, at minimum, should include:

- Establishment of an assessment protocol and referral process.
- Requirements for follow-up and notification of noncompliance to the state attorney's office.

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Ch. 11 Recommendations (pg. 266)

Criteria (cont.):

- Limitation on the maximum number of referrals for eligibility to participate in a pre-arrest diversion program.
- Requirement for diversion program referrals to be cumulative and eliminate a "reset" each school year for offenses counted for diversion programs.
- Requirement that all pre-arrest diversion programs report data to DJJ in Prevention Web* or another common database in an effort to eliminate information silos. (*Legislative appropriation will be required to modify DJJ's Juvenile Justice Information System to accept additional data).
- Specify that nothing in the criteria shall limit a law enforcement officer from making an arrest or interfere with a law enforcement officer's authority to enforce the law. Law enforcement shall retain discretion to decide if an arrest should be made.

128

Ch. 12: Cruz's Behavioral Threat Assessment

129

Ch. 12 Cruz's Behavioral Threat Assessment (pg. 273)

1. The 2016 threat assessment of Cruz was mishandled by Assistant Principal Jeff Morford. Morford was not familiar with the threat assessment process and he was incompetent in leading the TAT. Further, Morford's statement that he does not recall the Cruz threat assessment in 2016 and cannot answer detailed questions about what occurred is not credible.

2. MSDHS Principal Ty Thompson was disengaged from the threat assessment process at MSDHS and he failed to establish reporting procedures that would ensure he was knowledgeable about threats on campus.

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Ch. 12 Cruz's Behavioral Threat Assessment (pg. 273)

3. The BCPS threat assessment process is comprehensive and has the necessary components, but its implementation is flawed, at least at MSDHS. School administrators lack adequate training on and knowledge of the threat assessment process and how to conduct effective behavioral threat assessments.

4. The BCPS threat assessment process is decentralized, school-based and focused around behavioral threat assessment teams at each school.

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Ch. 12 Recommendations

132

Ch. 12 Recommendations (pg. 273)

- The BCPS should investigate Morford' s conduct surrounding the Cruz threat assessment process and take action it deems appropriate based on its investigation. The District should also investigate whether Principal Ty Thompson's disengagement from the threat assessment process and failure to ensure he was knowledge about threats on campus violated District policy.

- BCPS should immediately evaluate the implementation of its threat assessment process and training and determine if there is a districtwide problem with how threat assessments are conducted or whether the problem is isolated to MSDHS. Immediate remedial action is necessary. The BCPS threat assessment process is reactive and it needs to be proactive so that the TATs obtain information about concerning behavior before they manifest into actual threats. The TATs should seek out information and not merely wait for reports from staff or students. This applies to TATs across all Florida schools.

133

Ch. 12 Recommendations (pg. 274)

- The guiding principle for the threat assessment process should be behavior and not an actual threat. The traditional reactive threat assessment process is one that focuses more on actual threats as opposed to identifying concerning behaviors and intervening early. The most successful threat assessment process is proactive and often requires tying together disparate behaviors so they may be evaluated in the aggregate, viewed holistically and acted upon at the earliest possible time.

- The TATs should have permanent members. Rotating TAT members does not allow for consistency and personnel do not gain the necessary experience when rotated on and off the TATs.

- There should be District oversight of the TAT process and District level review of all Level 2 assessments. Principals should be required to be informed of every threat assessment and the Principal should approve the disposition of every assessment.

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Ch. 12 Recommendations (pg. 274)

- The Florida DOE should develop a statewide behavioral threat assessment instrument and create a statewide threat assessment database that is accessible to all districts and appropriate stakeholder. Florida should consider the model used by State of Virginia, which is widely recognized as the leader in school-based behavioral threat assessment.
- The Legislature should pass a bill requiring this process be implemented by DOE by a date certain. DOE should be provided oversight authority for the threat assessment process
- All TATs should be comprised of specific (static) members with at-large positions for each case for school personnel with personal knowledge of the child. TATs should be required to meet at least monthly and be proactive, not just reactive. The TATs should receive regular training on threat assessments.

135

Ch. 12 Recommendations (pg. 274)

- TATs should be required to convene within 24 hours of receiving a referral when school is in session. If school is not in session, the TAT must refer the matter to law enforcement for evaluation and the TAT must meet on the first day school is back in session to consider the matter and ensure it is resolved.
- All school personnel should receive mandated training on behavior indicators that should be referred to the TAT for assessment. Reporting observed behaviors to the TAT should be mandatory. There should be sanctions for non-reporting.
- There must be adequate resources to which the TAT can refer a child—the TAT is a problem identifier and not a problem solver.

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Ch. 13: Cruz's Educational Services

137

Ch. 13.2 ESE/IEP (pg. 278)

1. The Broward County School District engaged the Collaborative Educational Network, Inc. (CEN) to conduct a review of the ESE program activities related to Nikolas Cruz. CEN is a subject matter expert in this area. A redacted version of the report was made public but some information related specifically to Cruz remains confidential. The CEN report concluded that the district mostly adhered to procedural and substantive requirements when implementing Cruz's exceptional education program.

2. However, where the District failed was when it erroneously told Cruz that he could not remain at MSDHS and receive ESE services and that his only options were to withdraw from ESE or go back to the ESE center at Cross Creek.

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Ch. 13.2 ESE/IEP (pg. 278)

2. (cont.) The onus was on the District to seek a court determination if it wanted to force Cruz to attend Cross Creek and it misstated Cruz's options to him which caused Cruz to withdraw from ESE and all services. Cruz remained at MSDHS until February 2017 when he transferred to an adult learning center. Cruz subsequently sought to return to high school and to reengage ESE services but the District failed to implement the necessary processes that would have returned Cruz to high school. Cruz remained in the adult learning center environment without ESE services until the shooting.

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Ch. 13 Recommendations

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Ch. 13 Recommendations (pg. 280)

- There should be a Florida workgroup established to determine necessary changes to federal law regarding ESE and then coordinate with the Florida congressional delegation to request the identified changes. State law changes can follow if federal law is revised.
- School personnel must be properly trained on their ESE obligations under federal and state law so that the requirements are not under or over applied.
- Threat Assessment Teams and IEP committees must coordinate information and courses of action regarding ESE students.
- Students with IEPs that involve severe behavioral issues should be referred to and evaluated by the threat assessment team.

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Ch.14: Florida Safe School's Assessment Tool

142

Ch. 14 Florida Safe School's Assessment Tool (pg. 282)

1. When we look at the districtwide FSSATs submitted between 2015 and 2017, it appears that the FSSATs submitted in 2015 (the first year of the automated system) were lengthy reports, many over 100 pages.

2. There was no MSDHS specific assessment submitted during this period.

3. The FSSATs submitted in years 2016 and 2017 by school districts across Florida appear to be perfunctory submissions, with most in the 25 page range that contained simple self-serving yes responses to questions.

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Ch. 14 Florida Safe School's Assessment Tool (pg. 283)

4. In 2015, four districts did not submit a districtwide FSSAT; in 2016 five districts failed to submit an FSSAT; in 2017 seven districts did not submit FSSATs and the 2018 reports were due October 31, 2018 but several districts did not submit reports.

5. As to the optional school specific assessments, in 2015, the first year of the automated FSSAT, out of 3,900 schools only 116 were shown completed in the FSSAT system and the number declined from there with only 16 assessments reported in 2017—16 out of 3,900 schools in the year before the MSDHS shooting.

6. There were no consequences for non-compliance with the FSSAT process.

144

Ch. 14 Florida Safe School's Assessment Tool (pg. 283)

7. DOE did not, and still does not, have regulatory authority over the districts. DOE is the entity that the districts report the data to but DOE does not oversee the districts submissions, or lack thereof. DOE did provide training to the districts on completing the FSSAT.

8. There are numerous concerns with the FSSAT instrument in addition to the lack of submission accountability and perfunctory responses. The instrument itself is problematic in that it asks questions that are mostly long narratives for which the call of the question is a self-serving yes or no response. There is minimal call for a substantive narrative response to FSSAT questions.

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Ch. 14 Florida Safe School's Assessment Tool (pg. 283)

9. In addition to the overall FSSAT deficiencies, the districtwide and MSDHS specific FSSATs submitted by the BCPS contain inconsistent statements and lack the necessary information to effectively assess physical site security within the Broward County school district or at MSDHS.

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Ch. 14 Recommendations

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Ch. 14 Recommendations (pg.283)

- The legislature should require that the FSSAT be the primary instrument used by the school districts to assess physical site security.
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- The Florida legislature should provide DOE with compliance authority over the districts to ensure that each school, and each district as applicable, submits an annual FSSAT.
- DOE should be tasked with, and funded for, providing each district with training on how to assess physical site security and how to properly complete the FSSAT.
- Each site assessment should be required to be conducted in conjunction with law enforcement.

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Ch. 14 Recommendations (pg.284)

- The annual districtwide FSSAT should specifically set forth the physical site security priorities for the district in descending order of priority.
- The FSSAT should also explain what progress was made in implementing the previous year's FSSAT priorities.
- It should be required that any significant deficiencies identified during the FSSAT assessment process that adversely affect the safety and security of any school campus or facility must be timely reported to school board and a remedial plan approved by the board.
- The legislature should provide statutory sanctions for non-compliance with the annual FSSAT submission requirement.

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Ch. 14 Recommendations (pg.284)

- The legislature should require that the school specific FSSAT be approved by the superintendent or his/her designee before submission to DOE. The designee must be a deputy/assistant superintendent or the district's School Safety Specialist.
- The current school specific and districtwide FSSAT should be revised with stakeholder input, especially from law enforcement and industrial security experts.

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Ch. 15: Information Sharing

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Ch. 15.1 Federal and State Privacy Laws Affecting Information Sharing—School, Medical & Mental Health Records (Florida Educational Privacy Requirements, FERPA, and HIPAA)

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Ch. 15.1 Federal and State Privacy Laws Affecting Information Sharing (pg. 292)

1. Based on the testimony before the Commission and discussion among Commission members, it is evident that there is significant misunderstanding and over-application of several privacy laws, including FERPA and HIPAA. The misunderstanding and over-application of privacy laws is a barrier to necessary and successful information sharing.

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Ch. 15.1 Federal and State Privacy Laws Affecting Information Sharing (pg. 292)

2. Many aspects of educational privacy laws fail to consider appropriate exceptions for an incident such as this where full public disclosure of prior conduct, especially misconduct is beneficial and necessary. The inability for public disclosure of probative information and the attendant information void leads to misinformation and distrust that erodes the public's confidence in the system and it officials. If there is to be an erosion of public trust it must be based on fact and not speculation because information is hidden form the public eye.

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Ch.15 Recommendations

Ch.15 Recommendations (pg. 299)

1. There needs to be extensive training provided to all stakeholders on the appropriate application of FERPA, HIPAA and other often misunderstood and over applied laws. The over-application of these laws and the barriers that imposes must cease. Knowledge of the laws' exceptions are as equally important as their initial applicability.

2. The Florida legislature should consider changes to Florida school privacy laws that are not preempted by federal law to better allow information sharing in appropriate circumstances, and to encourage changes to federal law.

3. The Florida congressional delegation should evaluate FERPA, HIPAA and other federal laws and sponsor changes to those laws that will allow broader information sharing and public disclosure.

Ch.15 Recommendations (pg. 300)

4. SESIR reporting requirements to DOE and law enforcement should be evaluated and increased. Several types of incidents, such as robbery, not now required to be reported to law enforcement should be required reportable offenses.

5. School Districts must ensure that each school accurately reports all required SESIR incidents and that under-reporting is eliminate. School districts should be held accountable for accurate reporting and the districts should hold their administrators accountable.

6. The legislature should provide DOE with SESIR oversight authority and authorize DOE to impose sanctions on districts that do not accurately report required data. DOE should be provided inspection authority of districts' records and be required to conduct audits to ensure compliance.

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