I. MY JOB TITLE, DESCRIPTION AND DUTIES

My former title held at MDAS was Clinic Supervisor. My duties included, but were not limited, shelter population management, disease control, staff accountability, training, schedules, payroll, inventory, tracking surgery complications, statistics for the shelter, spay/neuter, and safety of the Clinic Section. I oversaw 13 vet technicians and was responsible for hiring, firing and discipline of my staff. The following documents are included to support/describe my duties and performance:

A. Job Description and welcome letter, 2011 (Exhibit 1)

B. Six Month Performance Evaluation (Exhibit 2)

C. One Year Performance Evaluation (prepared by Kathleen Labrada, late) (Exhibit 3)

D. One Year Performance Rebuttal (Exhibit 4)

II. MISUSE OF PUBLIC FUNDS

A. Prior to the promotion of Labrada to Chief of Enforcement and Operations, a 5 Year

Performance Report from 2005-2010 was released. The report shows a steady record of over 30,000 pets coming into MDAS, with a notable increase during the housing market crisis. While that increase is likely related to large scale pet owner displacement during the financial crisis in 2008, the average intake is still over 30,000. This is the standard number for intakes for Miami Dade County. Please see report attached hereto as Exhibit 5. What is significant about this report is it shows how all animals were accepted upon intake and not turned away, unlike now. It also shows that owner surrender euthanasia requests were counted in the overall euthanasia rate, unlike now. Finally, it demonstrates the positive impact of live release procedures was already evidencing success in increasing live release rates which is the equivalent of decreasing euthanasia rates.

B. Additionally, please find report prepared by Dr. Sara Pizano that shows the euthanasia rate for fiscal years 2001 through 2010. Dr. Pizano's report also demonstrates a steady decline in the euthanasia rate. Please see report attached hereto as Exhibit 6.

C. Beginning in 2012, the first year Alex Munoz was Director, the intake numbers remain consistent with the ten year trend, totaling just over 29,000 pets. Please see compilation report for the years 2011 and 2012 demonstrating the monthly euthanasia rate report attached hereto as Exhibit 7.

D. In April 2013, when MDAS stopped including euthanasia requests by owner in their statistics the euthanasia rate reduced dramatically. Please see 1st and 2nd quarter intake and outcome statistics report compiled monthly as Exhibit 8. Please note that euthanasia requests are not reported in the month of May and the category is removed entirely.

E. In other words, euthanasia requests by owner are not included in the euthanasia rate of the shelter, but the animals are being euthanized. Why is this important? This is important because the false statement of reduced euthanasia rates not only led to Munoz getting an additional $4million dollars for his 13-14 budget from Mayor Gimenez, MDAS was also getting grant money from the American Society for the Prevention of Cruelty to Animals ("ASPCA"). Please see ASPCA Partnership Grant Proposal, Excel Spreadsheets to accompany Grant Proposal demonstrating false live release rates, a prior draft of the proposal and meeting minutes about the grant proposal attached hereto as Composite Exhibit 9. The proposal was seeking $294,300 with the majority of the funds going to MDAS.

F. July 3, 2012, the Board of County Commissioners releases a Memo regarding the No Kill Resolution to be developed using the "No Kill Equation." The resolution charged the Mayor or his designee (MDAS and Mayor's buddy, Alex Munoz) to develop the plan. Please see Memo attached hereto as Exhibit 10.

G. In August 2012, Director Munoz holds meetings with each section of MDAS, to discuss three topics of public concern: "Pit Bull Ban/No Kill Resolution/Pets Trust". He discussed how all three initiatives are not directly affiliated with MDAS, but that all groups are working together "toward a common goal to save more lives." Please see August 15, 2012 meeting Agenda attached hereto as Exhibit 11.

H. Already in 2012, however, employees began to realize the reports were not including the outcome of all pets. An email from Melissa Sorokin in November 2012 discusses inconsistencies in the number of live releases missing from the monthly reports. See email attached hereto as Exhibit 12.

I. While the dreams of the "No Kill Equation" continued in the background, the movement of the Pets Trust gained momentum when over 500,000 voters voted in November 2012 to increase taxes and support the lifesaving initiatives of the Pets Trust – including, but not limited to, spay/neuter clinics and other community outreach plans. Please see Miami Herald article from November 2012 attached hereto as Exhibit 13.

J. The Pets Trust funds would raise $19 Million and would be overseen by a board to be used to increase life-saving missions in Dade County. Director Munoz would not have control over these funds and the shelter would not be the sole recipient of the funding according to the Pets' Trust Plan of Action dated January 2013 and attached hereto as Exhibit 14.

K. In July 2013, Director Munoz meets with Mayor Gimenez and promises he can accomplish "no kill" initiatives without the $19M, but rather could accomplish this with only $4M directly into the Animal Services Budget. The Mayor decides to "find $4M" in the budget and award this amount to Director Munoz for the fiscal year '13/'14 budget. Please see Miami Herald article dated July 16, 2013, discussing the outrage of the voters attached hereto as Exhibit 15.

L. On the heels of this article, my "on the book" efforts to directly and immediately decrease euthanasia in the shelter by releasing public "euthanasia candidate lists" got attention from the Miami Herald in two articles dated July 25, 2013 and July 26, 2013 attached hereto as Composite Exhibit 16.

M. Munoz became furious that I gave the honest and open interviews to the Herald. Subsequently I was marched into Labrada's office and told that my honesty about the conditions of the shelter killing was "out of line". A note from his desk, in his handwriting, shows that according to his calculations, the shelter's pet population is the same in 2013 as it was in 2012 and 2011. He also highlighted for me, several portions of the first page of the July 26, 2013 article with which he disagreed. Please see handwritten Munoz notes attached hereto as Composite Exhibit 17.

N. Even though his shelter reports show that his management had reduced shelter intake to only 27,000 pets impounded in 2013. Please see May 19, 2014 press release attached hereto as Exhibit 18, where Munoz indicates a suddenly much lower intake number.

O. In response to the verbal reprimand and what I felt to be a gross misrepresentation of the actuality of the shelter, I prepared the Clinic Section review and proposal for consideration in the '13/'14 budget. Please see proposal attached hereto as Exhibit 19. This presentation demonstrates the increased services required from the clinic staff, and the 3 year long freeze of hiring new full time staff for this section. Also, I discuss the mismanagement of resources and make several suggestions on how processes could be more efficient, thus not only saving lives but also saving the County's money. Suggestions included the restructuring of clinic services to reduce required points of contact between the shelter and the vet staff by 33%, streamline the adoption process by implementing a plan that would take care of the adoptable animals in one shot at the clinic for vaccines, microchip and heartworm testing. Although it may seem like the spending on pets that may not be adopted by inserting microchips and providing heartworm testing is a waste of resources I demonstrated through work flow analysis it is not. More staff hours are spent looking for animals that cannot be located due to the shear incompetence of the kennel staff and the lack of proper management to oversee it and make sure it runs smoothly. Other suggestion is to fully utilize the Chameleon database and eliminate the reliance on handwritten notes to streamline veterinary care.

P. Director Munoz held several meetings discussing the plans for the additional $4M in the budget, including the creation of 60 new positions. Included here are some examples of meetings and emails of from which I was purposely excluded. Please see three separate examples of where I was purposefully excluded from meetings and the ability to have access to initiate work orders meaning I could not even ask IT for help without going through someone else not from IT first attached hereto as Composite Exhibit 20.

Q. On January 19, 2014 I submit another large scale analysis which was a further extrapolation of my prior proposal that was prepared for the 2013-2014 fiscal year budget, this time a complete financial analysis of the inefficiencies of the intake procedures and financial benefits of restructuring the procedures that could result in saving the county over $250,000 a year. Please see proposal attached hereto as Exhibit 21.

R. Also included here are two emails, from 2011 and 2012 respectively, discussing some of the same critical issues addressed by this efficiency plan. Please see emails attached hereto as Composite Exhibit 22. Not surprisingly, management did not respond to this proposal while I was there. However, make no

mistake, within two months of my elimination, MDAS took my proposal and implemented same thereby increasing efficiency at MDAS.

S. Five days after I submitted my proposal, on January 24, 2014 I was notified that my position had been eliminated from the budget. Labrada and Virginia Diaz discussed this decision with me in person, saying they had been acutely aware of the elimination since the budget implementation as of October 2013, and chose to inform me nearly four months later as they looked for the veterinarian to replace me to head the Clinic Section. The elimination letter cites “fiscal challenges” as the reason my position was eliminated. When I asked how they could justify the elimination of my position in a year when the department’s budget had been increased by the Mayor 40% they had no response. Further, the department created over 60 new positions, most of which I was qualified for, yet did not offer me any of those positions. It is my belief that due to my numerous attempts to shed light on their many misuses of county funds I was eliminated from the budget to strategically remove me from a position to become a whistleblower. See January 24, 2014 letter attached hereto as Exhibit 23.

T. Also attached please see December 18, 2013, rejection letter for a position that I applied and a job announcement dated January 14, 2014 for four positions for which I was overly qualified but could have applied for had I known of my elimination attached hereto as Composite Exhibit 24. Note all four positions were conveniently closed on January 21, 2014, just three days prior to my elimination.

U. The ‘12/’13 Organization Chart reveals that the position held by Labrada appeared officially this year, however no interviews were held and that position was never publicly posted. In fact, that position was created by Director Munoz, specifically for Labrada, and she was given a Chief title without even holding a four year degree. To be clear, all Chief positions require a four year degree, except Labrada’s. Please see chart attached hereto as Exhibit 25.

V. A review of the organizational charts demonstrates a vast increase in the number of overall staff at Animal Services for the ‘13/’14 year. Calling into question the need to “eliminate my position from the budget due to fiscal challenges.” Please see chart attached hereto as Exhibit 26.

W. In addition to the above mentioned violations to County Policy (not listing job descriptions, not opening recruitment for new positions, and waiving degree requirements for favorites), most recently I applied for the position of “Outreach Specialist.” This position is not listed on the ‘13/’14 Organizational Chart and during the interview with the panel comprised of Gilda Nunez, Luis Cuellar and Michael Leiva, they stated to me that I was actually interviewing for the position of “Volunteer Coordinator, it’s just listed under the name of Outreach Specialist.” Please see Exhibit 26 described above with the flag that says “Outreach Specialist.”

X. Furthermore, not only is the $4M being used to create positions that are not reflected on the organizational charts approved by the Mayor, but the job postings on the county job website do not include job descriptions. There is no accountability for the tasks of these new employees. Please see Email job announcement dated January 13, 2014 attached hereto as Exhibit 27.

Y. Upon reviewing these documents and noting the inconsistencies herein, I requested the official job description for the position of "Treatment Veterinarian;" the position currently occupied by Alejandra Duran, DVM and the position created in the process of eliminating my position. The description of this new position grossly underrepresents the list of duties contained within the position of "Clinic Supervisor," and more disturbing is the fact that Dr. Duran has already had this position, in 2010, prior to my arrival. She voluntarily stepped down from the position due to a widely publicized scandal involving accusations of the illegal practice of "heart sticking" live pets during euthanasia. Please see description for treatment veterinarian attached hereto as Exhibit 28. Please compare this description with the email job announcements presented in Exhibit 27 and described above.

Z. Also attached please find the voluntary demotion letter for Dr. Duran (please note memo is dated incorrectly with the start of 2011) and news article dated January 12, 2011 describing the heart sticking incidents attached hereto as Composite Exhibit 29. AA. Emails reveal that the plan had been in place to replace the Clinic Supervisor position with the Treatment Veterinarian position since well before I was notified on January 24, 2014. Please see email chain ending with the date of January 16, 2014 attached hereto as Exhibit

30. In this email I was curious as to who veterinarian assistants were going to report to since vet techs report to the clinic supervisor which was the position I held. The response given is that the Treatment Veterinarian would oversee the vet assistants. Vet assistant was a new classification of employee that was identical to vet techs, minus surgical assistant rotation.

BB. MDAS, Labrada in particular, fail to follow the requirements of Collective Bargaining Agreements, as discussed in further detail below in Section IV, infra, to actually be effective in disciplining staff for bad behavior. The case of Bernard Perry, Animal Control Officer ("ACO"), will be discussed here instead of below because in the end, Mr. Perry was able to reverse his termination and receive a giant check for all back pay missed while fighting said termination. Mr. Perry received one check in the gross amount of $40,181.18 and a net amount after taxes and other deductions of $20,351.85. Mr. Perry received a second check in the gross amount of $1,902.23 and the net amount after taxes and other deductions of $1,228.67. In other words Mr. Perry received over nine (9) months of back pay for a period where MDAS had terminated him while he fought the termination. While Mr. Perry was out, it is presumed that other ACOs had to pick up the slack that resulted from his absence or another ACO had to be hired to replace him. Attached hereto is Composite Exhibit 31, consisting of Mr. Perry's reinstatement letter dated April 23, 2013, Arbitration Decision dated April 22, 2013, Copies of pay stubs evidencing payment of back pay, Mr. Perry's termination letter dated July 6, 2012, June 12, 2012 Memorandum regarding Mr. Perry's Disciplinary Action Final Determination Meeting, Memorandum from Bernard Perry to Labrada dated February 15, 2012, September 18, 2007 "job well done" email from Director, Sara Pizano, and a May 30, 2012 letter from constituent, Josephine Rodriguez, about Mr. Perry's excellent performance (May 30, 2012 would be in the time period after his initial disciplinary meeting and his official termination). Although, the Arbitration award speaks for itself, there is something that is incredibly noteworthy on page 34 of same. The Arbitrator found it telling that the author of the termination letter, Alex Munoz, did not testify at the arbitration proceeding. The arbitrator indicated "that failure puts the finder of fact in the position of wondering exactly which factors were considered in the administration of discipline."

One could infer that Mr. Munoz sending his second in command at MDAS, Labrada, instead of attending himself, that Mr. Munoz simply rubber stamps everything that Labrada puts across his desk. Mr. Munoz does not even like to put things in writing so nothing comes back to him. It begs the question if Labrada is able to do whatever she pleases in the eyes of the Director, who polices this County agency and why is Munoz getting a paycheck at all? Mr. Munoz makes almost $200,000 a year to be a silent "yes man" to Labrada.

It is well known that Munoz was appointed the Director position of MDAS after his original position in the County Manager's office was dissolved. He did not apply for this position and has made it abundantly clear that he is just there to collect a paycheck until he is eligible for retirement or transfer. There are plenty of people that would love to have his position for less pay (or at least donate a substantial portion of the pay back to the animals) that actually want to be at MDAS and want what is best for the shelter, the County, and the public at large.

III. FALSIFICATION OF COUNTY DOCUMENTS

A. Misrepresentation by Animal Control Officers ("ACO") of Live Release

Numbers Used for Personal Gain Resulting in Unearned Merit Based Increase of Wages

(Exhibit 32): On or about October 26, 2013, I had a conversation with Serrano after receiving information on how at least one ACO was lying (falsifying) on county records, in such a way that would lead to unearned merit based increases for the ACO. In other words the fraud permits the ACO to essentially receive pay raises that he otherwise would not have earned but for the fraud/falsification of the county records. This is accomplished in the following manner:

1. The ACO picks up an animal in the field and gives it a new I.D. number without checking for a chip, which is against protocol.

2. The ACO then brings the animal back to MDAS, scans it for a chip and realizes that the animal already has an I.D. number in the system.

3. The ACO then outcomes, or closes out, the new I.D. number as a "returned to owner in field" even though the animal is still sitting in the kennel under their original I.D. number. To be clear the animal was not actually ever returned to its owner in the field or otherwise; it is sitting in the shelter.

This is a stealth way of stealing money from the County. Every I.D. number closed out (outcomed) as "returned to owner in field" results in a point for the performance statistic of the ACO.

Performance statistics are used to give merit based pay raises to the ACO for a "performance well done". This particular ACO in this example is still there, still working as a lead working and has never been disciplined or had these particular actions addressed. Email chain with ACO, Sam Gafcovich, and dated October 26, 2013, discussing this practice is attached hereto as Exhibit 32.

B. On or about September 22, 2013, it became apparent that when the Kennel department changed its record merging system in Chameleon, it was creating duplicate results.

For example the attached email demonstrates that pet A1549930 was given another number A1555568 because of their failure to properly identify the animal as already in the MDAS system under its old number. So when the "merging" of the records takes place the newer number (A1555568) is written over with the older number (A1549930) and now the older number has two records both of which need to be outcomed. So here the dog was euthanized but because the record has to be closed out twice, it gets reported as two euthanasia deaths. If the dog had been adopted, it would have falsely reported as two adoptions on one dog and same with return owner, etc. See emails attached hereto as Composite Exhibit 33.

C. Falsification of kill rates and statistics that mislead everyone into thinking that the euthanasia rate at MDAS is substantially lower than it actually is.

1. While I was out on maternity leave a new Standard Operating Procedure on Euthanasia Requests ("SOP") was implemented on or about April 26, 2013. When I returned from maternity leave, I requested formal training on the newly implemented SOP.

In response to my request for training I was provided a copy of the SOP attached hereto as Exhibit 34. Upon reading the SOP, I had a discussion with Serrano and told her how uncomfortable I was implementing this SOP because it was misleading to the public and led to fraudulent statistics. Serrano had no response and directed me to follow it.

The SOP outlined a procedure to euthanize animals where they will not be reflected in the total euthanasia statistics of MDAS. To be clear owner euthanasia requests are not included in MDAS statistics on euthanasia, nor reflected on any report, income or outcome.

In other words, owner euthanasia requests are not reflected anywhere in any report or any statistic given out by MDAS. The owner requested euthanasia is only traceable in the handwritten owner requested euthanasia form and in the sodium pentobarbitol drug log.

An Animal I.D. number is given in a separate part of the database reserved for animals that are never impounded as a part of the shelter system but rather are registered to private owners. This is done by creating a U-Link number which is how an outside private veterinarian registers its rabies tags issued to its animal patients.

2. This has led to an abuse of process in two ways. The first way is if an animal is brought in by its owner and the receiving kennel employee deems the animal either unadoptable or low probability of being adopted based on factors such as behavior, age, looks or medical condition, the owner is instructed to fill out the euthanasia request form instead of the owner surrender form. If the owner refuses to fill out the euthanasia request form, the receiving kennel employee refuses to accept the animal into MDAS. This was reported in a recent undercover media report. A copy of the article is attached hereto as

Exhibit 35. A link to the video is: http://www.local10.com/news/video-shows-stray-dogsshunned- by-miamidade-animal-services/25062212.

3. One example is the case of Carmen Llinas. She was an elderly woman that came into the shelter with her three (3) ten year old dogs, A0952913 (cocker spaniel), A0715782 and A0633092 (both mixed small breeds). Her husband had to be placed in a nursing home forcing her to move in with her daughter where she could not take her animals. That particular day, the staff had been instructed not to accept any owner surrender only owner euthanasias, as per Labrada. Ms. Llinas was left with no choice but to complete the euthanasia request form for each of her pets. She was told to mark that the reason for the euthanasia request was that the pet had an illness although no illness is described per the form instruction. Excerpts from a power point presentation on this topic and the Owner Euthanasia Request Forms are attached here to as Composite Exhibit 36.

4. The second way that abuse of process occurs is best illustrated by example. There was the case of a cat hoarder where approximately 60 cats were confiscated and the hoarder was Baker Acted. These 60 cats were given a litter number upon intake of 10119014. Because the hoarder was Baker Acted, MDAS had the family come in and gave them the option to adopt some of the cats back. Once the family chose certain cats, MDAS marked all 60 as returned to owner only to instruct the “Owners” to complete euthanasia request forms for the remaining cats not adopted by the family. Again, these 60 cats are not reflected in the euthanasia statistics, and are reflected as live release numbers, fraudulently improving the euthanasia statistics at MDAS. Copies of records are attached hereto as Composite Exhibit 37.

5. As a side note, this cat hoarding case is an example of another violation of MDAS policy and procedures. For weeks after the original euthanasia request form was signed, MDAS was bringing in additional cats, allegedly from the cat hoarder’s property, and killing them under the original euthanasia request form and simply hand writing the animal identification number on the original form. What should have happened is those cats should have been presented to the family for re-adoption or evaluated by the vet for adoption. This resulted in even more cats being left out of the euthanasia statistics. This is one more example of widespread falsification of County records.

D. MDAS is not in the regular habit of scanning pets when the pet presents as a stray to try and connect the pet with its owner if it’s lost.

1. On or about January 21, 2014, Marc Kramer, a veterinarian that works on the Mobile Animal Clinic (“MAC”) expresses his concern that not enough is being done to find the owner of the animals presented to the MAC for spay/neuter surgeries. He is only suggesting that the animals simply be scanned for a microchip which is not happening resulting in “lost/stolen” dogs passing through the county when they could be reunited with their owners. See email attached hereto as Exhibit 38.

2. Leo Romero and Labrada continue to ignore their new impound procedure for euthanasia request pets is grossly inadequate.

a. On August 4, 2013 it became apparent that the intake technicians were not noting tags or scanning for chips. A0669056 was picked up as a Stray on July 24, 2013. The intake picture of the dog actually

shows there is a tag on the animal that went ignored. The dog was fearful and aggressive and was slated for euthanasia due to length time on floor and behavior. When the dog was presented for euthanasia, the technician saw the tag and refused to euthanize the pet (a practice demanded of all staff I supervised during my time of employment). The owner was contacted and the owner's daughter raced up to MDAS to claim the dog. The dog was nearly killed and sat unnecessarily in MDAS for 11 days when it could have been reunited with its owner much sooner if kennel staff properly did their job. See email attached hereto as Exhibit 39.

b. On October 27, 2013, a poodle was presented as a euthanasia request but was never scanned for a chip upon impound. When I addressed this with the staff they informed me that they were not aware they had to scan pets for microchips to confirm the identity of the pet prior to presenting the pet for euthanasia. Any number of pets with microchips could be killed without ever being properly identified. This is in direct violation of the identification of pets policies, even when impounding owner surrenders and strays. In this case, the animal had a chip so that it could be verified if the person who presented the dog for euthanasia was the dog's rightful owner. Please see email attached hereto as Exhibit 40.

IV. FAILURE TO HOLD STAFF ACCOUNTABLE FOR ABUSE

Part of my job was to discipline the staff for failure to follow standard operating procedures. Once I made a disciplinary decision, I would submit a formal record of counseling to Labrada for review and approval. She would review them at her leisure, in an untimely manner. Her perpetual delays in disciplinary actions resulted in several complaints to the staff members' Union representative. On most occasions, MDAS loses these grievance hearings due to consistent negligence on the part of MDAS and Labrada to follow the simple rules outlined in the Collective Bargaining Agreements (see also example above regarding Bernard Perry). In some cases, Labrada sat on the record so long, the disciplinary action was never presented to the employee and the wrong doing never corrected.

There are three prime examples of this failure: Anthony Casas ("Casas"), Abdel Perez ("Perez") and Alain Vera ("Vera"). Both employees filed grievances against MDAS for submitting late performance evaluations. I refused to complete these performance evaluations while these disciplinary actions were pending, having been submitted to Serrano and Labrada for weeks or months. Based on their performance, I would have been inclined to give a less than favorable review. I would have been unable to discuss the reasoning for the unfavorable review, because Labrada could not follow proper procedures with respect to the disciplinary action process and the collective bargaining agreement.

A. Failure to Follow Progressive Discipline: Anthony Casas

Casas is a veterinary technician with a documented history of tardiness, not following directives and procedures, wrongful euthanasia, misuse and improper injection of class 3 federally controlled substance known as sodium pentobarbital that led to unnecessarily painful euthanasia of pets, and gross negligence. His actions led to the euthanasia of the wrong animals, to taking animals out of the computer alleging the animals had been euthanized when it had not and was still on the premises not being properly cared for because no one knew the animal was alive, death of animals from prolonged distress based on his negligent actions and improperly injecting the controlled substance via an illegal

administration. Mr. Casas still works there to this day. Copies of supporting documentation is described below and attached hereto.

1. Three Statements from Dr. Roy Maura, Misael Rodriguez, and Garson Dupuy describe how Mr. Casas misused the sodium pentobarbital. Specifically, Dr. Maura signed a statement about a conversation had with Mr. Casas where Mr. Casas admitted to injecting a dog named Rex, A1544834, intramuscularly with the sodium pentobarbital and acepromazine (the non-approved euthanasia cocktail experiment made up by Mr. Casas). Mr. Casas could not say how much he had given. When he was reminded that it was inhumane, immoral and unethical to inject the animals with sodiumpentobarbitol intramuscularly, his response was that the animals appear to feel no pain every time he does it. Mr. Rodriguez and Mr. Dupuy gave supporting statements as to the occurrence of this conversation, see Composite Exhibit 41.

2. Portions of Casas disciplinary file regarding the following three situations:

a. A1460456 was not euthanized in real life and was sitting in the shelter, but was outcomed in the computer database as having been euthanized. Composite Exhibit 42.

b. A1461677 was euthanized in real life but not outcomed in the computer, so the animal was thought to be alive somewhere but missing. Composite Exhibit 43.

c. A1472650 was euthanized, was not supposed to be euthanized and was not outcomed in the computer database while A1472644 was not euthanized, but was supposed to be euthanized and placed in the shelter with A1472650's kennel card. Composite Exhibit 44.

3. Portion of Casas disciplinary file of a situation where he was responsible for pet, A1480010 who was placed in cage in his designated area. He was caught on video kicking the sick pet stuck in the cage to see if it was still moving. He did not check on the pet for the remainder of the day, like he was supposed to and the pet was found deceased four hours after he first kicked the cage. He then lied when confronted about when he "checked" on the pet, which led to the review of the video that showed the time stamp and him kicking the cage. Composite Exhibit 45.

4. Various records that demonstrate Mr. Casas inability to follow very simple, idiot-proof procedures such as:

a. Removing pets from public view online with Pet Harbor prior to euthanasia, not euthanizing some pets, and not returning the pets to public view on Pet Harbor when he did not get around to euthanizing the animal Composite Exhibit 46;

b. Speaking to the media during hurricane preparation, in direct violation of shelter directives, where he was quoted in the news that MDAS accept snakes (when they do not) Exhibit 47;

c. Failure to clock in and out upon arrival and departure in an effort to steal time he was not there; failure to follow chain of command and dispersing inaccurate information to the staff; failure to remain in his designated area for the day and neglect the animals in that area for hours; and failure to follow dress code policy. Composite Exhibit 48.

5. Email regarding Performance Evaluation of Casas is attached hereto as Exhibit 49. Please note on page 4 of the email, on July 18, 2013, I am being asked to resubmit an evaluation without "subjective commentary" because the probationary period for the subject of the subjective commentary had passed. It passed because Labrada refused to follow the progressive discipline procedures and Mr. Casas was never disciplined for his horrible behavior. Additionally on page 2 of the email on August 1, 2013, Labrada indicates that she will sign the Casas evaluation. Labrada breaks chain of command because the Chief Veterinarian, Dr. Serrano oversaw the Clinic Section of which Mr. Casas was a part and was the one who was supposed to sign off on Mr. Casas' evaluation.

B. Failure to Follow Progressive Discipline: Abdel Perez

Perez was also a veterinary technician and is now the lead worker, a newly created position. Perez has a documented history of wrongful euthanasia, failure to follow euthanasia procedures and not following directives and procedures. His actions also led to the euthanasia of the wrong animals, to taking animals out of the computer alleging the animals had been euthanized when they were not and still on the premises, not being properly cared for because no one knew the animal was alive. After all of his failures and shortcomings, he was awarded employee of the year for 2013 by Labrada and Munoz. Copy of the supporting documentation are attached hereto and described below.

1. An email that documents an incident where A1566118, a yorkie, was sent to euthanasia by the vet and Mr. Abdel outcomed the pet as having been euthanized as A1565712. A1565712 was a miniature pinscher with a rescue hold in place. Exhibit 50.

2. Documentation of three separate incidents where pets A1544884, A1554036, and A1554705 were outcomed in the computer database as having been euthanized when they were not euthanized but sitting on the shelter floor. The pets were not receiving care and not in public view on Pet Harbor because no one knew that the pets were alive. This created much outrage amongst the public because shelter staff was reporting what was in the computer, that the animals were dead and they were not. Exhibit

51.

3. Emails documenting over two months of requests/reports that proposed disciplinary action regarding Mr. Perez and his inability to follow the euthanasia protocol (some instances described above at Exhibits 50 and 51). Ultimately, Mr. Perez was never disciplined and was later promoted. Please see Composite Exhibit 52.

C. On occasions when I would try to resolve issues directly with the Union representative, Labrada would remind me that I was not allowed to speak to anyone outside of my direct Chain of Command under any circumstances. See Email from Labrada attached hereto as Exhibit 53.

D. Failure to Address Complaints of Abuse: Alain Vera Aguilera

On three separate occasions, two employees and one veterinarian made complaints regarding inappropriate behavior of an employee identified as "Alain", a/k/a Alain Vera Aguilera, who works in the

kennel section. I sent all three complaints to Kennel Supervisor, Leo Romero, and Kennel Lead Worker, Rachel Hernandez, as well as Labrada. On all occasions I was informed the situation was investigated. The employee in question was not reprimanded formally, and has been promoted since these complaints. Please see supporting documentation described below and attached.

1. Complaint by Dr. Anik Chavez complaining of Alain beating an American Bulldog on the head multiple times attached hereto as Exhibit 54.

2. Complaint by Jessica “Jessie” Garcell complaining of Alain hitting a dog hard, identified as dog A1577113, while trying to feed him attached hereto as Composite Exhibit 55.

3. Complaint by Veronica Vazquez complaining of Alain kicking a dog in his kennel so the dog, A1580724, would move to the other side of the kennel. Despite Ms. Vazquez yelling for him to stop, he did not; attached hereto as Composite Exhibit 56.

4. Newsletter circulated by Alex Munoz from April 2014 demonstrating Alain’s promotion to receiving clerk (bottom right hand corner of page); attached hereto as Exhibit 57.

V. SAFETY OF THE ANIMALS, STAFF AND THE PUBLIC

A. Failure to follow basic protocols by leaving gates open in West Wing resulting in death to animals and placing volunteers and staff in harm’s way. The kennels are often left unlocked and the staff in the kennel fails to follow procedures regularly. Below are the various examples of incidents that occurred as a result of this failure. Every time an incident occurred I brought this failure to the attention of MDAS upper management, specifically, Labrada and Munoz. Every time I brought these incidents to their attention, I was ignored.

1. On September 6, 2013, Anastasha A0583031, a sweet black lab, escaped her kennel because it was left unlocked. She was charged by two other dogs that also escaped their cages because their cages were left unlocked. Kennel staff was present, but not really available as it was after hours and they were cleaning up after an adoption event. The attack on Anastasha resulted in injuries so severe that she ultimately had to be euthanized. Of the two dogs, dog A1328215 was the main aggressor and was also euthanized because of this preventable event. With MDAS upper management, being fully aware of what led up to the death of Anastasha, they did nothing to correct the situation. Medical case files regarding Anastasha and the aggressor dog, A1328215, with specific veterinarian notes are attached hereto as Composite Exhibit 58.

2. Additionally, color photographs of the damage caused to Anastasha prior to her euthanasia have also been included as Exhibit 59.

3. On the same evening, another dog Lola, escaped her cage, and was found dead in the road in front MDAS because she had been hit by a car. Lola’s case file is attached hereto as Exhibit 60.

4. On October 6, 2013, this continued failure to correct the situation led to a volunteer, named Harriett, almost being attacked by a dog, named Hugo, from an unlocked cage. The volunteer was passing Hugo’s

cage with members of the public who were interested in another dog for a potential adoption. Fortunately, for everyone involved, the volunteer was able to secure the cage with her foot while she waited for kennel workers to come and properly secure the cage and Hugo. An email documenting this event is attached hereto as Exhibit 61.

5. On December 1, 2013, a German shepherd, A1127608, escaped his unlocked cage, and approached an extra-large mastiff, A1576610, in another unlocked cage. The two dogs began fighting through the cage and during the fight managed to open the door because the mastiff's cage did not have a lock. A kennel worker, George, was by himself and could not break up the fight alone. He had to run away from the situation to get help from Alyssa, a technician, and Carlos, another kennel worker in breaking up the fight. Additionally, there was no safety equipment in the area to assist in breaking up the fight, i.e. catch poles. An email documenting this event is attached hereto as Exhibit 62.

B. Reckless Disregard for Safety: Staff, Volunteers, the Public, and Pets

1. The Public

a. An example of gross negligence regarding public safety and humane treatment of pets involving bite reports occurred on September 27, 2013 when a jogger was bitten in a park ("bite incident"). On October 16, 2013, I questioned Labrada regarding her practice of killing 5 dogs bearing identification numbers A1558014, A1558016, A1558140, A1558266, and A1558319, allegedly involved in the single bite incident. None of the dogs looked the same and comprised of males and females. As a result of the bite incident, animal control rounded up various dogs and MDAS never had the jogger identify the biter dog. This failure resulted in 5 dogs being quarantined and then euthanized after the quarantine period expired after no dogs showed evidence of rabies, at the direction of Labrada. These dogs were also not tested for behavior to see if there was a potentially adoptable dog in the bunch, although staff commented several were friendly. Originally, Labrada wanted all 5 dogs rabies tested at the Health Department. However, without bite reports as to all dogs the Health Department would not process all dogs for "head to lab" rabies testing with only one bite report. "Head to lab" rabies testing is where the dog is euthanized, decapitated, the head is cleaned and prepared and then sent to the lab for testing on the brain because rabies testing can only be done postmortem on the brain. Due to the sloppy follow-up on this case on behalf of Labrada, the victim could therefore not be provided with accurate disease screening information and had to wait over ten days for the quarantine period to end before she could have been treated. Email chain documenting practice attached hereto as Exhibit 63.

b. On or about September 1, 2013, a dog A1552907 was brought in as an owner surrender for biting an individual other than the owner. The biter was placed in the sick ward, needlessly exposing it to illness, which is against procedure.. It sat in the sick ward with no information or pictures in the system for three days until I started asking about it on September 4, 2013 in various emails. The dog was impounded as a fearful dog and not as a biter dog exposing the staff and volunteers to a potential known harm without warning. On September 5, 2013 I follow up again with the enforcement supervisor, Sean Gallagher, about the status of getting any information about the biter dog into the system. Shortly thereafter, I am presented with a backdated bite report dated August 29, 2013 about the incident that

took place on August 23, 2013. This report also demonstrates that it took the enforcement division 6 days to respond to the bite report. Please see case file attached hereto as Composite Exhibit 64.

2. The Staff

a. On various occasions, MDAS has failed to address threats of physical harm against the staff from sources outside the shelter.

i. In May 2012, I received death threat from Mr. Jerry Edelman in a private message on Facebook where he told me that I needed to be dragged out in front of the rescued community and publicly euthanized. See print out of exchange attached hereto as Exhibit 65.

ii. On September 19, 2012, I was trying to explain to a member of Urgent Dogs of Miami, a rescue group, that just because a euthanasia log indicates the initials of the staff member who euthanized a pet, it does not mean that the staff member ordered the pet to be euthanized. The orders for euthanasia come from either a supervisor or veterinarian. See email attached hereto as Exhibit 66.

iii. On the same day, I sent an email to Munoz' assistant, Gilda Nunez, explaining to her that the euthanasia logs being disseminated in without redaction was inciting hate on Facebook within the rescue community because certain groups used these logs to make "kill lists" and would post them attributing "kills" to certain staff members and personalized the job task of euthanasia and equate to the staff member enjoyment as related to the "kills". This actually put staff members in danger because the rescue community knew enough staff members, in addition to public records, to call them out by name on Facebook. Please see sample chart attached hereto as Exhibit 67.

iv. Recently, in April 2014, the MDAS staff newsletter went around honoring Erwin Arreaga for coming to the defense of another staff member from a physical attack by a member of the public. A copy of the newsletter is attached hereto as Exhibit 68.

b. Staff and volunteers are in danger due to the inability to have proper safety equipment.

i. On or about October 12, 2012, Erwin Arreaga was in the process of euthanizing and animal when the needle because disengaged and sprayed Sodium Pentobaritol into his eye. He immediately went in search of an eye wash station and NONE could be found in the entire shelter. After a Union representative complained to the head of MDAS about the lack of eye wash stations on November 1, 2012, they were finally replaced on November 2, 2012. See emails documenting situation attached hereto as Composite Exhibit 69.

ii. On or about November 13, 2012, Veronica Vazquez, a kennel worker was attacked by a dog named Mitt A1477113. Veronica was ultimately blamed for the attack, counseled for her behavior when there was nothing she did wrong in the situation. The cages were being cleaned and the dogs moved around. Mitt did not have kennel card and there was no mention of him being aggressive. Mitt showed no signs of aggression allowing her to place the dog back into its regular kennel and only attacked when she turned to leave his kennel. Alex Grijalba went to Veronica's aid and was also attacked by Mitt sustaining injuries that left Alex hospitalized for approximately one week. There was no catch pole in the entire

wing where they were working which is a required piece of safety equipment and necessary for staff safety in dealing with aggressive animals. Please see incident statement signed by Veronica Vazquez on November 28, 2012 attached hereto as Exhibit 70.

iii. I was the only supervisor that worked weekends and the only supervisor that was denied access to the video cameras. Eventually, all supervisors my level lost their rights to the surveillance equipment just so I would be denied access and it would not come across as unfair treatment or prejudicial in any way. One example of why access to the cameras was necessary occurred on or about November 4, 2012, while I was the only supervisor on duty, a former staff member returned to hang out with the staff even though he was prohibited from returning to the premises. This particular staff member was terminated for making repeated violent threats against other staff members. I asked him to leave without incident but it could have been a dangerous situation. It was for everyone's safety that I had access to the surveillance system so I could ensure that he left the premises and was not lurking anywhere without walking the entire shelter which is enormous. The email documenting this example is attached hereto as Exhibit 71.

3. Pets in danger due to actions of shelter staff.

a. In an effort to reduce euthanasia rates and shelter intake numbers, MDAS came up with a widely known and practiced policy of not accepting feral cats, unless the person who brings in the cat agrees to let the cat become a part of the TNR/TNG program. TNR stands for trap, neuter and release. TNG stands for trap, neuter and give back to the person who brought in the cat so that person can release the cat back to the area from where it was picked up. This policy was a spoken policy, but not written. On September 18, 2013, a man brought in a black garbage back full of cats and tried to turn them in. He was not interested in TNG because he did not want the cats back in his area and insisted he leave the cats or take matters into his own hands outside of the shelter. The written policy of the shelter is that all animals surrendered by the public at large are to be accepted. Please see emails documenting the situation and portions of a power point presentation outlining the cat acceptance policy featuring this situation as an example attached hereto as Composite Exhibit 72.

b. In an effort to save the shelter money, so Labrada claimed, BioSpot, a flea and tick preventative, was first implemented on or about October 12, 2012. There was no research done into the safety and efficacy of the product prior to implementing the change. The staff was not notified and no training was provided. Further there was no current Material Safety Data Sheet ("MSDS") available as required by OSHA. This type of BioSpot was in packaging that is not currently sold in the United States. The packaging looked so old that the white portions of the label had yellowed. This was important because upon my own investigation, I discovered that the chemicals in the preventative were lethal to cats, no current MSDS could be found and there is a website dedicated to victims of BioSpot:

biospotvictims.org that goes back to 2002. Fortunately, due to my quick thinking and research, no animals were harmed because I refused to use the product. Please see emails attached outlining this event as Composite Exhibit 73.

c. Activyl Tick Plus, a flea and tick preventative, was first implemented on or about November 9, 2012 after a representative for the company came to MDAS for a demonstration; Exhibit 74. During the training we were informed that it was not safe for use on any feline due to pyrethrin toxicity. Despite expressing my concerns that this was a bad idea as it was not safe for all shelter animals, MDAS proceeded to use it anyway. What the representative did not tell us during training, is that it takes four hours for the product to evaporate on its own or not washed off completely, permitting cross contamination of the cats causing the cats to die a slow, horrible, painful death involving multiple seizures leading to multiple organ failure and death. Although no exhibits are attached to demonstrate this, Dr. Serrano had to euthanize several cats due to this type of cross contamination and describes the reason for euthanasia in her notes. Furthermore, there are many videos on youtube of cats dying from pyrethrin toxicity if a mental image is needed to understand how harmful and cruel this preventative is.

d. Additionally, not found out during the training, but on the floor when a litter of 5 puppies was also given the Activyl Tick Plus when they suffered the same fate as the cats on or about July 31, 2013. Necropsies were done on the 5 puppies at a third party laboratory, Idexx. Upon information and belief, the necropsies were actually paid for by Pfizer to prove it was not their vaccine that caused the death by systemic failure in the puppies. The necropsy results indicated that it could only be the only Activyl Tick Plus that killed the puppies. Merck, the maker of Activyl Tick Plus, performed its own analysis and came to the same conclusion as the original results. However, despite all this data that this preventative is unsafe for a majority of the pet population at MDAS, Activyl Tick Plus is still used today. Attached please find Composite Exhibit 75 outlining the details of the Activyl Tick Plus events described above.

e. On or about April 2012, the floor cleaner was changed to Tech-5000. The chemical would be sprayed into the runs to clean the kennels and would not be rinsed thoroughly causing chemical burns on the dogs in sensitive areas like their genitals. Emails were sent on June 14, 2012, June 30, 2012 and August 23, 2012 documenting severe chemical burns on male dog genitalia to Serrano and Labrada. These are not all the emails that were sent documenting these burns, just examples attached hereto as Composite Exhibit 76. It is believe that the floor cleaner was finally changed out to something safer on or about July 2013. For over a year, dogs suffered burns due to the failure to follow standard operating procedures in removing floor cleaner and disregard of the caustic properties of the cleaning chemical.

f. On or about August 27, 2012, after Tropical Storm Isaac rolled through after a Pet Friendly Evacuation Center ("PFEC") I sent an email to Labrada, Serrano and Virginia Diaz ("Diaz") demanding a debriefing regarding the KROP action plan that provides for the policies and procedures in setting up a PFEC. While setting up for Isaac, I realized that basic supplies were missing from the list violating OSHA, i.e. a biomedical hazardous waste container for the needles/syringes. See email attached hereto as Exhibit 77.

VI. GROSS MISMANAGEMENT OF POLICIES, STANDARD OPERATING

PROCEDURES, TRAINING AND STAFF ACCOUNTABILITY

A. Failure to follow up on wellbeing of adopted or rescued pets

MDAS is not only responsible for the care of the pets in the shelter but is also in charge of the investigative unit responsible for the enforcement of Chapter 5 Miami-Dade County Code of Ordinances for animal welfare in the community. In two notable cases, MDAS failed to intervene when shelter pets were being taken from the shelter and given to known animal “hoarders” or otherwise individuals under investigation for animal cruelty: Gisela Tacao, Diana Peters and

Cocker Rescue.

1. Gisela Tacao:

a. Labrada was first made aware of the conditions of some of Ms. Tacao’s animals in September 2011. Ms. Tacao had a history of contacting MDAS in an effort to get free vet care because she lacked funds. In the example from September 3, 2011, I explain to Labrada about how Ms. Tacao wanted MDAS to treat her small dog that had been attacked by a larger dog and its eye was dangling out of the socket and she could not afford care. Ms. Tacao contacted veterinary Technician Grace Davin directly and told her this information on the phone in my presence. Labrada responds the same day that said the facility was just inspected but she would put in for a cruelty check. On September 5, 2013 Tacao informs Labrada that Debi Day donates $2,000 to her every month. Finally, on September 13, 2011, Labrada informs Tacao the complaint is unfounded and closed. See attached here to as Composite Exhibit 78.

b. Ms. Tacao not only pulled dogs under her rescue name, but pulled them under the names of other rescues including SOS4Paws and told Labrada in an email on May 17, 2012 that she pulled many dogs under this other rescue which is in violation of MDAS policy. See attached here to as Exhibit 79.

c. The 2014 State v. Gisela Tacao, Case no. F14-7559 case stemmed from Ms. Tacao’s turning over of 70 dogs to Tricounty Humane Society. These dogs were in deplorable condition. Ms. Tacao’s decision to turn these dogs over stemmed from a code enforcement violation run-in with the City of Hialeah on or about August 3, 2012. Specifically, Chief Code Enforcement Officer Violeta Blanco, and several other officers inspected her warehouse after receiving several complaints from neighbors to the warehouse. Ms. Tacao had sent an email to Dahlia Canes describing the incident and then forwarded the email to Labrada on August 6, 2012. Please see email chain attached hereto as Composite Exhibit 80.

In Ms. Tacao’s version of events two things were notable: Ms. Blanco’s comment that the dogs would be better off dead than in Ms. Tacao’s warehouse and that she does not dump dead dogs in her dumpster because she takes her dead dogs to MDAS so that MDAS can close out the animals account. Besides describing the site as one where dogs are better off dead than at this rescue, it does not prompt an investigation by Labrada and MDAS. Additionally, Ms. Tacao informs the reader that MDAS is aware and has an accounting of every dog that dies in her care and has the ability to inspect the deceased pets’ condition upon intake of said deceased pet. This does not trigger an investigation by Labrada and MDAS. She tells Ms. Labrada that the email is being sent to Dahlia Canes so Ms. Canes can have a politician friend make the situation go away.

In fact, Labrada, is so “alarmed” by the conditions of Ms. Tacao’s warehouse and barrage of dead pets brought back to the shelter that she writes a reference letter on Ms. Tacao’s behalf on September 26,

2012 that Ms. Tacao's rescue is in full compliance with the County and entirely on the up and up per MDAS and Miami Dade County Code standards.

d. In emails and "orders to provide medical care" I provided Labrada with the information and requested follow up. For example, regarding pet named Sissy, ID A1491411, an investigator requested follow up medical care and closed the case once she received a note from the veterinarian that the animal was treated for an upper respiratory infection. The ASD investigator failed to read the medical waiver explicitly requesting further diagnostic testing to determine the health condition of the pet. Please see email and supporting documentation attached hereto as Exhibit 81.

e. This pet was later recovered from Ms. Tacao's house as a part of an ongoing cruelty investigation on April 17, 2014. Please see a copy of the letter from the State Attorney's Office dated May 16, 2014 attached hereto as Exhibit 82.

2. Diana Peters: Ms. Peters was banned from adopting animals on behalf of her "rescue" since at least 2011 and maybe earlier. She began coming in with other individuals, selecting dogs she wanted, and then the individuals would adopt the dogs for her. In emails and "orders to provide medical care" I provided Labrada with the information and requested follow up. No follow up was ever conducted in the case of Diana Peters, specifically, dogs named Ed-A1571492 and Ted-A1567881. Please see email string and medical history of animals attached as Exhibit 83.

3. Cocker Rescue of Fort Lauderdale: On or about January 23, 2013, I brought to Labrada's attention concerns regarding this rescue. This rescue "saves" animals out of MDAS and then drops them into a local boarding facility without having any sort of adopter or plan for the dogs. The dogs are then shipped all over the country without being spayed or neutered, without medical records, or proper medical follow up. The local boarding facility is charging for the shipping of these dogs. The end adopters of the dogs are under the impression the dogs came directly from MDAS and are contacting the Clinic trying to get medical services, records and and/or treatment for the dogs. Please see email attached hereto as Composite Exhibit 84.

B. Gross Negligence Tracking and Updating Inventory of Shelter Pets

MDAS uses a database named Chameleon to track all pets that move through the shelter. Current management has knowingly allowed staff to disregard standard operating procedures, resulting in the loss of pets from the shelter, misidentification of pets presented for euthanasia, loss of the public's pets presented for outpatient surgery, and a dangerous disregard to provide tracking ability for diseased pets.

1. Shannon A1377581 is an example of a pet that went "missing" within MDAS on September 15, 2011 and was "found" on September 22, 2013. Throughout the time she was "missing", she was being sought for medical treatment of kennel cough which is highly contagious. Please see email complaining of same as Exhibit 85 attached hereto.

2. Donna A1573426 is an example of a pet that went missing on December 4, 2013. The location of the pet was never investigated by the kennel staff who just outcome her as “missing”. On December 19, 2013, I conducted an investigation and located Donna who was no longer in the shelter and had been removed with her sister, Bella. I notified both Kennel and Front Counter Supervisors, and after a week the record was still not updated to reflect the correct information. Please see email trail attached as Composite Exhibit 86. There are dozens of pets that go missing every month.

3. Dexter A1385575 was a male American bulldog that made it on to the euthanasia list when I was covering the euthanasia technician rotation. When “Dexter” was presented for euthanasia, I actually received a female American bulldog named Chi Chi A1385948 (see pictures attached as Composite Exhibit 87.) that was wearing Dexter’s I.D. band. Although, the dogs looked similar, they were clearly different and not even the same sex. As it turns out Dexter had gone “missing” and has never been found. I refused to euthanize the unidentified pet and notified Labrada. No follow up was ever conducted.

4. On or about July 26, 2013, Maria Rodriguez, an elderly 83 year old woman, presented her cat for outpatient sterilization surgery on the Mobile Animal Care Unit (MAC). When she came to pick up her beloved pet, she was given the wrong cat. Her niece brought this to our attention on July 31, 2013. Her cat was never located. Labrada stopped my investigation into the whereabouts of the cat when I came to the conclusion that Mr. Omar Chavez needed to be questioned since he was the last employee to receive the incorrect cat. This case was never resolved and the elderly woman was never given a conclusion for the disappearance of her beloved pet. What is believed to have happened is that Ms. Rodriguez’ cat was swapped for a Trap, Neuter and Release (TNR) cat and was ultimately released back into the streets. Conveniently, the wrong cat, once returned back to MDAS, disappeared without a trace. At a minimum, had the wrong cat’s original intake information been located, the location where Ms. Rodrigues’ cat was released could have been discovered. Please see file on Ms. Rodrigues and her cat attached hereto as Composite Exhibit 88.

5. As Clinic Supervisor, a part of my job included disease tracking, documentation and prevention. Two well-known, highly contagious, and deadly diseases, Parvovirus (for canines) and Panleukepenia (for felines) must be tracked within the shelter because if it spread it could kill hundreds of other pets. When Labrada came on board in 2011, she started systematically cutting my access to various systems to demonstrate her “power” even when it was detrimental to the wellbeing of the shelter population. Labrada and Munoz decided to change my ability to access the Kennel History window in Chameleon which eliminated my ability to track the movement of pets throughout the shelter and placed hundreds of pets at risk of cross contamination with deadly diseases. See attached Composite Exhibit 89 comprising of emails from November 10, 2011, October 17, 2012, November 11, 2012, February 6, 2013, October 23, 2013, November 15, 2013, and December 4, 2013.

C. Failure to Train and Discipline Staff Regarding Disease Control Procedures

1. Standard Operating procedures requiring Kennel Staff to change gloves and wear gloves while handling pets were put in place Leo Romero, Kennel Supervisor on October 9, 2011. See memorandum

attached hereto as Exhibit 90. Despite this directive being in place the staff continues to show disregard for this life saving protocol; Romero and management is unwilling to address these concerns or hold employees accountable for their actions.

2. One example occurred on or about November 7, 2012 when the cat litters are being mixed, thereby spreading diseases. I asked the Kennel Supervisor to do something about this and later informed Dr. Serrano and Labrada. See email attached hereto as Exhibit 91.

3. Another example is a woman named Katherine Dean, an animal care specialist that was often scheduled in receiving never wore gloves and was never disciplined. As you can see in the photographs in the attached Composite Exhibit 92, taken in October 2013, Ms. Dean is not wearing gloves. One dog is documented as having Parvo at intake and the other as being sick (and later it was learned to be "sick" with Parvo). Every dog she touched after the sick dogs risked contracting Parvo because it is highly contagious and could have been left on her hands. As it is a non-enveloped virus, it is not eliminated by use of normal cleaning protocols or antibacterial soap, even if Ms. Dean actual washed her hands. It is believed she did not because there is no bathroom near that room.

4. Pet of the week A1550744 had been confirmed Parvovirus positive on August 31, 2013. She sat in the euthanasia/kill room, a/k/a "A" Ward all weekend in isolation, while being networked with rescues and treated for her illness. On her fourth day she was euthanized for potentially and "needlessly" exposing other animals that were about euthanized to the Parvovirus. It is well known that animals who make it to through their fifth day will most likely survive the Parvovirus illness. Despite treatment and networking and the dog not taking up any space on the adoptable part of the shelter floor, Labrada gave the directive to euthanize the dog anyway. Please see email dated August 31, 2013 with screen shots attached hereto as Exhibit 93.

D. Gross Oversight of Veterinary Care and False Veterinary Statements

1. During my tenure at MDAS, it became apparent that no one was checking the notes on the animals prior to the animal receiving surgery. This was problematic because many animals were not medically cleared for surgery. The veterinary technician would not check the notes and would sedate the animal anyway. The vet did not have the ability in the surgery room to check the medical notes on the computer and was only presented with an already sedated animal and, accordingly, would perform the surgery increasing the animal's chance of death. See email chain attached hereto as Exhibit 94.

2. On or about October 17, 2012, it was realized that a dog named Gigi,

A1469447 went 9 days without receiving a skin scrape or any veterinary care. The dog presented on October 4, 2012 and did not receive a skin scrape or see the vet until October 13, 2012. Please see email and documentation attached hereto as Composite Exhibit 95.

3. On or about September 6, 2013, Todd A1552037, was placed on a vet check list and was to be treated for anaplasmosis. He did not receive any treatment, nor was he seen by a vet until September 10, 2013. On September 11, 2013, a vet made a note that the dog should be euthanized for not responding to

treatment. It is clear that the vet did not check the notes and presumed the dog had been on treatment since the 6th. Obviously, less than 24 hours is not adequate time to respond to treatment, particularly for this type of tick born blood disease that causes severe anemia. See email and documentation attached hereto as Exhibit 96.

4. On or about November 3, 2012, a dog named Tay A1480081 was euthanized because there was a veterinarian's note stating he was "unable to walk." However, this was not the case. In his intake pictures he is standing and happens to favor his front left leg. Minutes before he was euthanized, I was playing with him and had gone back to my office to complete a write up on Tay to see if I could get a rescue organization to pick him up that specialized in senior adoptions. By the time I returned to get additional pictures of Tay, Dr. Duran had already sent him to the kill room where he had been euthanized. I even have a witness statement from Melissa Sorokin that she witnessed Tay playing and walking. He was euthanized before his legal stray hold period was up, which is 5 days. He was killed for no urgent medical condition, less than 12 hours after arriving at the shelter. Although Tay was not in perfect condition, he was certainly not suffering to the point where euthanasia was the only option. See Composite Exhibit 97.

5. On or about November 29, 2012, a dog named Charlee A1487947 was euthanized approximately 20 minutes after arriving at the shelter as a stray. The dog was skinny, but not emaciated as the notes indicate. The animal was checked by Dr. Duran for crepitus which is the grinding of bone, more or less. Standard care dictates that the animal should be sedated to check for injury believed to be of that level of severity. So one of two things happened: either Dr. Duran caused extreme pain to the animal by checking it for crepitus without sedation or the dog was never checked for crepitus and she made up her diagnosis. There are pain meds at MDAS that could have treated the painful abdomen and certainly if no crepitus was found there was no medical way to determine possible fractures that might require immediate euthanasia. Similar to Tay, above, Charlee was killed well before his legal stray hold was up. Although his condition was not perfect, he was not suffering to the point where euthanasia was the only option. The picture in the attached Exhibit 98, is hard to decipher, it is clear that the dog is "smiling" with its jaw dropped in a relaxed position with the tongue wagging, essentially, making the "Heeyyy" face. The relaxed body language are indicative of a pet not in distress.

6. On or about July 8, 2012, approximately 6 dogs were impounded within one hour of each other and all were euthanized upon arrival for having "skin conditions" and "unable to open eyes." These dogs included: Gio A1447320, Kara A1447318, Kandy A1447322, Curtis A1447324, Melanie A144326, Herb A1447327. Although the pictures are hard to see (and Herb's is missing), it is clear that none of the dogs are in distress. One dog is relaxed and "smiling" and another is calmly laying down, but it is clear her eyes are open. It is more likely than not, that Herb was not photographed because Dr. Maura had already unnecessarily ordered death for the entire group of pets who only required simple medications for their skin condition. Please see attached here to as Exhibit 99.

7. On or about August 17, 2013, a dog named Maggie A1549089 was killed on arrival by a poorly trained animal control officer because Dr. Maura refused to come in to the shelter late at night and evaluate the animal (this officer was trained by Gafcovich and was terminated a few months later). Accordingly, Dr.

Maura directed the animal control officer to euthanize. She is described as limping with lacerations and "exposed bone". According to senior ACOs present on scene that night, and verified by her intake picture, there was a small laceration on her front right paw that exposed the bone for approximately one centimeter of the laceration's total length of approximately two inches. It is clear from the picture that she is putting weight on all four paws and does not appear to be in any distress. See Exhibit 100 attached hereto.

8. On or about September 19, 2013, a dog named Fizzy A1556273 was killed immediately upon arrival for being "comatose." This note was hand written and signed off on by Dr. Roy Maura. The dog is sitting upright with open eyes in the picture. Although the face is not clear in the picture, common sense dictates that if the dog was in fact comatose that it would not be able to sit upright as if waiting treat. See Exhibit 101.

9. On or about September 8, 2013, a dog named Stella A1554216, Dr. Serrano refused to evaluate a dog that had been so severely attacked by another dog in the house that it seemed to be in shock because it could not walk or stand according to the animal control officer. The animal control officer contacted Dr. Serrano at home and she advised to give the dog antibiotics and Rimadyl which is similar in efficacy to Advil. The notes indicate that there were several bleeding wounds on the ears, front legs and throat. Dr. Serrano, without seeing the dog, advised the animal control officer that the dog was BAR (bright, alert and responsive) and not in shock which is totally contrary to the animal control officer's observations and descriptions. Please see Exhibit 102.

10. On or about January 16, 2014, Animal Control Officer, Stacy Brito, expressed her concern that animals who are placed on the vet check list are not being checked for at least two days, if at all. A0489552 was brought in to the shelter by Ms. Brito on January 12, 2014, after a concerned citizen had found the dog loose and suffering from what appeared to be heat exhaustion with a very unstable back end. When Ms. Brito double checked on the status of the dog she noticed nothing had been done to help the dog regarding the heat exhaustion and the dog had been in MDAS custody for 4 days. See email attached hereto as Exhibit 103.

11. On or about July 9, 2014, approximately 40 minutes after Maxi, A0717892 had been impounded as a stray, she was euthanized. The problem is that she had been scanned and properly identified in the system, but protocols were totally ignored and the registered owner was never contacted regarding the stray pick up. Additionally, the 5 day mandatory stray hold was not followed. So even if the staff at MDAS was too lazy or incompetent to contact the owner, the owner would never be able to find her pet because the stray hold was not followed. It is presumed that nothing will be done to follow up with the ultimate owner or the irresponsible rescue that put her in this position even after collecting over $700 of public funds online for her care, about the utter neglect this poor old girl suffered. It is safe to assume that had she came to MDAS in May in the condition she was turned in as in July, she would have been euthanized in May. According to the records, her only problem in May was she had heartworm disease. Two months later she is turned in emaciated, with severe dental disease, a heart murmur (presumably from untreated heart worm disease but no heart worm test was performed), corneal ulcer, severe arthritis and hip dysplasia. However, what is most confusing is Dr. Duran's initial assessment that the pet

seems stable, but then is in need of "urgent further" care and then at the end of the note the pet is suffering and needs to be euthanized. Ms. Maxi was euthanized four minutes after this note was written. Additionally, it should be noted that severe arthritis and hip dysplasia do not develop overnight. Please look at the intake picture of the "suffering" animal because she is essentially "smiling" so you can see her bad teeth and is demonstrating relaxed body language. If Maxi was suffering as Dr. Duran indicated was the reason for the euthanasia it was not apparent from the animal's face. Although, Dr. Duran reaches deep for a valid reason to euthanize this dog, it can only be presumed she was euthanized for being old and not cute and cuddly. Please see Composite Exhibit 104, attached hereto.

E. Roll out of the "Trap-Neuter-Give Back/Trap-Neuter-Return/Release" Program (TNG/TNR)– Gross Negligence to provide safety equipment, training and develop procedures prior to beginning an "off the books" program.

1. TNG/TNR was rolled out unofficially and without any Standard Operating Procedures. Standard Operating Procedures were not in place until August 2013 more than a year since the unofficial rollout in July 2012. Daily, upper management changed their minds about how the program should proceed. Accordingly, I regularly requested clarification for procedures so I could ensure proper training for staff and safety equipment. The union also became involved due to upper management's gross negligence for the wellbeing of the staff and the feral cats involved. Please see Composite Exhibit 105.

2. The big problem with the TNG/TNR program is it is a free program being paid for by the County that the community is largely unaware it is available to them. Accordingly, there have been several news articles and stories done on how the community is not necessarily in agreement with the program and having the cats released back to their respective areas. Please see attached Exhibit 106. The articles discuss widespread public discontent with the program and that it was not discussed with the community prior to its implementation. For a TNR program to be successful, the community must be in agreement and understand the benefits of the program. There is also a story that was done on Local 10 News that is not in print, but the 3 minute and 45 second video clip can be seen here:

http://www.local10.com/news/cats-humanely-saved-taking-over-south-floridastreets/

26280870. In this story one man has over 60 cats that have been dumped on his property and MDAS continues to dump these cats on his property and in neighboring areas where the cats are not welcomed.

F. Gross Negligence on the part of Management to Prepare, Train, Implement and Hold Staff Accountable for Procedures

1. On August 12, 2012, an email went out to upper management regarding the lack of procedures for the transport program and providing several examples, please see Composite Exhibit 107 attached hereto regarding the following:

a. May 13, 2012: no paperwork being provided to clinic regarding transport pets creating log jam;

b. June 2, 2012: failure to provide basic needs to pets as required by the transport program due to lack of standard operating procedures, so work was often done more than once;

c. July 18, 2012: transport program was ordering medications from the clinic without the support of a veterinarian as required by clinic standard operating procedures;

d. July 29, 2012; in an effort to facilitate transport program, a log book of pets being transported was created to document needed medical services when animals were presented to the clinic and this procedure was not being followed creating more work for all involved;

e. August 5, 2012: transport program and one particular rescue had blocked off all surgeries and then none of the dogs arrived on time for their surgeries from the offsite kennel facility causing vets and techs to be paid to stand around; and

f. August 11, 2012:

i. more surgical delays and more avoidance of the log book creating more backlog in clinic due to needed medical services for transport; and

ii. transport animals not scheduled for surgery are presented for "emergency" surgery so animal can make the transport and bumping adopted animal surgeries and transport program was ignoring informal protocol and placing immediate transport holds on incoming animals instead of waiting for stray period to be up. The transport program was initiated by the volunteer coordinator (a paid position at MDAS), Melissa Sorokin. It was never formally instituted by the County and no standard operating procedures were ever developed. Further, it was this informality that permitted MDAS to circumvent the County's mandatory bid process and allowed Melissa Sorokin's non-profit organization, Miami Dogs on the Move by Pawsitive 4 Life, n/k/a Dogs on the Move to run the transport program. See above Composite Exhibit 107.

2. On Page 2-3 of the ASPCA Grant Proposal that is attached hereto as Exhibit 108, and pages 2-3 are reattached for ease and convenience and taken from Composite Exhibit 9, it shows that approximately 20% of the funds allocated to the transport program for the salaried position of transport coordinator, comes from the ASPCA grant money while the remaining 80% comes from the County itself. In other words, the County gives approximately $36,800 for a salaried position while ASPCA gives $9,200 toward the salary of the position. One has to wonder if $15,000 is being contributed by the ASPCA to a transport fund which is to cover payment for the driver, food and gas, etc. that a substantial portion of the MDAS budget is also going toward the transport and is not clearly labeled enough on the budget line item to ascertain how much of the MDAS budget is going to the transport program, specifically Dogs on the Move, a group that did not bid for this job and was given the job by Labrada. Also $50,000 is given by the ASPCA for trailer expenses to transfer animals, how much is coming from the County?

3. On or about May 10, 2012 there were dogs slated for transport that were taking up space on the adoption floor and listed as unavailable for adoption when dogs who are not going on transport were being held in areas of the shelter not seen by public and the same animals were not on Pet Harbor

which is the online pet viewing site of adoptable pets. Therefore the adoptable animals not going on transport had no hopes of getting adopted due to lack of public knowledge that they were available for adoption. Meanwhile pets were being euthanized for lack of space all over the shelter including the adoption floor. See email attached hereto as Exhibit 109.

4. Labrada is the Chief of Enforcement and Operations and fails regularly to actually enforce animal cruelty laws when appropriate. On or about October 15, 2013, dog A1562546, on a medical release for skin condition and on January 10, 2014 the owner surrendered the dog with the skin condition still present. The animal investigator, Lisa Yambrich, agrees that the owner should be cited, but instead of citing the former owner, she passes the buck onto another investigator and the owner was never cited for neglect. Email attached hereto as Exhibit 110.

5. On or about October 21, 2011, a boxer bearing number A1137703 had been adopted as a puppy and found as a stray in horrible emaciated condition. I was inquiring as to enforcement of cruelty laws against former owners. See email with pictures attached hereto as Exhibit 111.

6. Acting Chief Veterinarian Dr. Serrano chooses to ignore questions posed by the public or deem them public records requests and deems them “unimportant”. See December 9, 2013 email attached hereto as Exhibit 112. Although Florida Statute 119 does not require the county to answer interrogatories or do extra work, it does require the county to provide documents or records that would answer the interrogatory effectively making the interrogatory a public records request.

7. On or about December 22, 2013, an email addressing several cross-section concerns which had gone unaddressed for months if not years. This email plea for a management-wide meeting to address imminent concerns regarding appropriate care for the pets went unheeded. Specifically, the email addresses 311’s inconsistent statements to the public about surgery times and protocols on the Mobile Unit (MAC), that cats presented for the TNG program wait in the hallway for hours for impound when there available vets sitting around available for surgery, protocols for three year rabies vaccines, and protocols for dogs adopted with heartworm. See email attached hereto as Composite Exhibit 113. These concerns were never addressed after the sending of this email.

8. On February 12, 2012, a new computer program was implemented by the County called Active Strategy in order to track county wide performance measures. At that time, I was responsible for inputting the euthanasia statistics according to my job description and training previously provided. I was not provided any training on Active Strategy and therefor prevented from adequately doing my job. On February 16, 2012, Virginia Diaz, assistant to Alex Munoz, and manager of budget and finance, asked for euthanasia statistics and I provided them via email and not via the link on Active Strategy. IT granted me access on June 16, 2012 and I immediately requested training. Training was not provided until October 31, 2012. On October 31, 2012, I was told by “Downtown” representative that I had four other measures linked to my name as being my responsibility to report them to the Mayor. On November 3, 2012, I requested training on the other four measures that I never knew I was responsible for or remove them from my name. I was never provided training and my name was never removed from the

measures. Please see Composite Exhibit 114 attached hereto. A few months later, Virginia Diaz tried to write me up for not keeping up with the other four measures.

9. On or about August 4, 2013, I sent an email to upper management regarding two issues:

a. Issue 1: choke collars and harnesses were being left on animals sitting in runs, which poses a choking hazard to the dogs. Four days later on August 8, 2013, choke collars still not being removed.

b. Issue 2: an aggressive dog is placed on the outside of a run with a label of aggressive. Meanwhile the dog on the other side of the guillotine door is labeled as normal. The handle for the guillotine door is on the inside with the dog labeled as normal. There is no indication to anyone on the inside that the dog on the other side of the guillotine door on the outside part of the run is aggressive. This lack of care has led to several injuries and deaths that could have been avoided. See emails attached hereto as Exhibit 115.

10. On or about August 2012, it came to my attention that a new field was added in the kennel screen of the Chameleon database. The field was added so that the shelter could keep track of whether the animal was intact or neutered upon intake in effort get a grant. No one told the clinic about this new field and that it did not pertain to them. So once the animal was neutered, the kennel intake field was also changed erroneously in an effort to accurately update the pet file. I had to go back into the system and try to recreate the original status from intake where possible. Please see Composite Exhibit 116, attached hereto.

11. In December 2012, puppies of four weeks old were being removed from their mother and put on the adoption floor by itself, and were given hard food to eat when they had no teeth to chew the hard food. Please see emails and pictures attached as Composite Exhibit 117.

12. Female puppies A1560010 and A1560011 (originally housed in kennels B01 and B15 and later moved to kennel H23) were placed on the adoption floor with kennel cards for a litter of puppies that had previously been housed in that kennel, H23, six months prior, as male puppies A1522531 and A1522532. Consequently, adopters were overlooking A1560010 and A1560011 because they kennel card said the pets were 7 months old when the pets were only two months old. It was never determined how this could have happened and staff was never counseled regarding the importance of properly identifying pets. Please see photographs attached hereto as Composite Exhibit 118.

13. On or about November 10, 2012 a request was made for overtime to be afforded for key veterinary technicians so that they could attend trainings and it went unanswered. Please see email attached hereto as Exhibit 119.

14. On or about November 1, 2013, Sean Gallagher of the Enforcement Section offered to provide training to the clinic staff regarding safe animal handling techniques. He overlooked half of the standard operating procedures, specifically, “Handling of Aggressive Animals.” He only attached the Standard Operating Procedure “Animal Handling and Restraint.” I provided Handling of Aggressive Animals and more detail from a training manual. Please see Composite Exhibit 120, attached hereto.

15. On or about September 14, 2013, there was just utter confusion due to continued failure to keep adequate records and follow standard operating procedures. Animal A1552460 appears to have been fostered out of the shelter on or about September 5, 2013 and then given an intake date of September 20, 2013 and picked up as a stray. Please see email attached as Exhibit 121. Two dogs were taken from a hoarder case and placed in the A ward because there was no other place to isolate them so that the general population was not contaminated in anyway.

16. Animal A1554713 was also from the hoarding case and had been placed right on the adoption floor regardless of the need to isolate to avoid contamination. Proper protocol as to how to handle the animals taken from the hoarder case is unclear. Please see email attached as Exhibit 122.

17. On or about November 18, 2011, it became apparent that there was an issue with ACOs placing brand new stray dogs inside the sick ward, a/k/a WW isolation a/k/a West Wing isolation (one section). Dogs stuck here have no chance of being adopted, found if lost, or seen by the public and are needlessly exposed to illness. Please see email attached hereto as Exhibit 123.

18. On or about November 20, 2013, Leo Romero gives a veterinary technician a directive that goes in direct violation to her Standard Operating Procedure to euthanize pets directly off the adoption floor without a two hour hold to see if an adopter is in line. MDAS is clearly not the most efficiently run and often has long wait times. The two hour hold is in place so that if a potential adopter selects an animal and takes the number to the front counter, the animal does not get euthanized while the adopter is in line waiting to adopt the animal. Please see email attached hereto as Exhibit 124.

19. After several attempts to further my skill set by requesting training, I was not allowed to attend one training convention even when I paid to attend and requested to use my annual time to attend in August 2012. The following year in September 2013, after I made a complaint regarding the same group of employees, including Maria Serrano, Leo Romero and Michael Leiva, who were repeatedly granted training expenses, management afforded me the time to attend a training but only if I paid my own way. A public records request for training expenses would reveal favoritism and misuse of training budgets. Please see emails attached hereto as Composite Exhibit 125.

20. Several employees were photographed in uniform consuming alcoholic beverages at a paid county event in July 2013. This picture was submitted by me via an anonymous email account. The staff was never formally counselled. Management simply told them not to post pictures of them drinking on Facebook while at paid County events. Please see email attached hereto as Exhibit 126.

21. On November 16, 2012, Dr. Duran performed emergency surgery on Pet A1482625. She was repairing a botched spay done earlier by Dr. Gansky. As you can see from the photograph, Dr. Duran failed to use a sterile field by not placing a sterile cloth on the body of the animal so its guts would not touch its skin and contaminate the dog internally. This breaks the most basic requirements for a safe and sterile surgical procedure. Unfortunately the pet died a few hours later. Please see email and photograph of surgery attached hereto as Composite Exhibit 127.

22. On July 11, 2012, I reported to Labrada and Serrano that Jamie from Jamie's Rescue, and approved rescue partner, came in and requested from several staff members the swab portion of the Parvo ELISA test kits. She was refused because those tests are meant for shelter animals at the direction of a veterinarian. A couple of days later, when I had to look for and ELISA test kit for a sick puppy I found the boxes we had in both clinic rooms was missing the portion requested by Jamie of Jamie's Rescue. No follow up was ever done or video surveillance screened to confirm who stole the swab portion of the Parvo ELISA test kits. Please see email attached hereto as Exhibit 128.

23. On or about November 13, 2011, subsequent to Labrada's promotion to Chief of Operations and her decision to terminate a veterinarian technician because of pressure from Facebook despite the fact that the technician did not violate any policies or procedures, my staff became concerned about being terminated for reasons not made clear in written procedures and policies. Randy Lorenzo euthanized a cat as directed by a supervisor and accidentally listed the outcome condition incorrectly as "feral" instead of "fearful". Regardless of the cat being feral or fearful it was to be euthanized. The standard operating procedures do not specify as to the relevancy of the condition nor does it indicate that an erroneous entry would be consequential in anyway. To prove a point to my staff that Labrada's authority could not be challenged she fired him for this minor infraction that violated no written policy after pressure from public Facebook posts. Labrada's actions that day by firing Mr. Lorenzo violated the progressive disciplinary procedures as mandated by the County. An email expressing the concerns of my staff regarding the euthanasia outcome standard operating procedure dated November 13, 2011 is attached hereto as Exhibit 129.

VII. CONCLUSION

In conclusion, these documents should shed serious doubt on the practices being used by current management at Miami Dade Animal Services. From eliminating an entire population of pets from the shelter statistics, to falsifying a live release outcome for dozens of confiscated cats, to the use of false reporting practices to score higher on performance metrics resulting in the false increase of merit based salaries, to a disregard for legitimate requests for training in favor of sending the same handful of employees on a "party budget," to the failure to follow the most basic

County Policies on job creation and posting, I respectfully request a thorough investigation be held regarding what can only be called the gross mismanagement of public funds and reckless endangerment of our community and community's pets.