PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 31, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: June 27, 2017			
Facility Information			
Facility name: AMIkids – Youth Environmental Services (YES)			
Facility physical address: 4337 Saffold Road, Wimauama, FL			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 813-671-5213			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Enrique Garcia			
Number of staff assigned to the facility in the last 12 months: 72 (who may have contact with residents)			
Designed facility capacity: 30			
Current population of facility: 30			
Facility security levels/inmate custody levels: Moderate			
Age range of the population: 14-18			
Name of PREA Compliance Manager: Willie Queen		**Title:** Director of Operations	
Email address: yes-do@amikids.org		**Telephone number:** 813-671-5213	
Agency Information			
Name of agency: AMIkids			
Governing authority or parent agency: *(if applicable)*			
Physical address: 5915 Benjamin Center Drive, Tampa, FL 33634			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-887-3300			
Agency Chief Executive Officer			
Name: O. B. Stander		**Title:** Chief Executive Officer	
Email address: O.B.Stander@amikids.org		**Telephone number:** 321-863-1497	
Agency-Wide PREA Coordinator			
Name: Wendell Watson		**Title:** Regional Director	
Email address: wlw@amikids.org		**Telephone number:** 321-863-1497	

AUDIT FINDINGS

NARRATIVE

AMIkids-Youth Environmental Services (YES) is a staff secure residential facility and is located in Wimauama, Florida. It serves male juvenile offenders who have committed a variety of non-violent offenses and are involved with the Florida Department of Juvenile Justice. The program primary focuses on academic and vocational education services; environmental education; behavior modification; and treatment. Programming services also include life skills training, mental health overlay services, substance abuse seravices, and behavioral health services. The facility's capacity is 30 and 30 residents were in the program on the day of the site visit. The length of stay in the program is six to nine months. The mission of AMIkids is "to protect public safety and positively impact as many youth as possible through the efforts of a diverse and innovative staff."

The Lead Nurse coordinates the medical services and also provides medical services along with another Registered Nurse. A physician visits the facility on a weekly basis and a Nurse Practitioner makes the visits when the physician cannot. Forensic medical examinations will be conducted at the Crisis Center of Tampa Bay in Tampa, Florida. Mental health services are provided by the Director of treatment; three Therapists; and a contract psychiatrist. Treatment and program staffs collaborate and interact with each other in the planning, facilitation and coordination of services to meet the comprehensive needs of each resident. Direct care staff members are responsible for the general supervision of the residents and assist in maintaining a positive environment. The comprehensive tour of the facility revealed that staff members engage the residents through their supervision style.

Academic, vocational and GED services are provided based on the individualized needs for each resident. The academic courses offered include English, Mathematics, Social Studies, and one elective course. The elective course is typically used to provide additional reading assistance or vocational training. Carpentry and computer technology are offered through vocational services. Residents also have the opportunity to earn ServSafe (Food Handler) Certification from the National Restaurant Association and local restaurant associations. Identified residents are able to obtain employment in the local community during their stay at the facility.

Residents are involved in the behavior management system that helps them improve their decision-making processes. The behavior management system rewards desired behavior and positive attitudes and help residents develop an awareness of the consequences of personal actions. Residents are involved in restorative justice activities that entails holding the residents accountable for their actions, helping them develop confidence and competency in vital life skills and educational areas, leading them to acceptance of personal responsibility. Staff provide support to residents, as needed, in their restoration efforts. The residents are also involved in community-based projects.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility is located on grounds that contain seven buildings that are attached or are in close proximity to each other. The primary building contains a reception area, offices and a conference room. The collective buildings contain three classrooms; two dormitories; multi-purpose room; token store; medical clinic; offices; laundry room; kitchen and dining room; and storage areas. There is a building that contains work space for teachers and education space that may be utilized as needed; a building for vocational education; and a building that contains the weight room. There are no isolation rooms. The outside grounds contain areas where residents may engage in various recreational and other activities.

The PREA information was observed posted in areas of the facility during the comprehensive tour.The bathroom with showers and toilets is located in each dormitory. Procedures are posted which support that a reasonable amount of privacy is provided for the residents to change clothes, shower and use the toilet. A sign is posted at the outside entrance to the housing units instructing female staffs to announce themselves when entering the housing units. The residents reported that generally the female staff members do not enter their dormitories and upon the rare occasion that it happens, females do announce their presence.

An upgrade to the camers system has been completed since the last PREA Audit in 2014, and include that 30-40 days of recordings are stored and can be viewed. The facility has a color-code system that indicates where residents are allowed only with staff and areas where residents are not allowed. During the comprehensive tour of the facility, a grievance box was noted to be posted. The number of staff currently employed at the facility who may have contact with residents is 43.

SUMMARY OF AUDIT FINDINGS

Prior to the site visit, a conference call was completed with the PREA Compliance Manager who also serves as the PREA Compliance Manager and the Florida Department of Juvenile Justice (FDJJ) statewide PREA Coordinator and a FDJJ program manager. During the conference call introductions were made and the audit process was discussed. Printed signs announcing the audit and this Auditor's contact information were posted; pictures were taken and sent to this Auditor via email. The areas were identified of where the signs were posted and they were in areas accessible to the residents, staff and visitors. The PREA Pre-Audit Questionnaire, policies, and supporting documentation were uploaded to a flash drive and mailed to this Auditor. After an assessment of the information provided, a written review was sent to the Director of Operations/PREA Compliance Manager, requesting clarification of information and additional documents. There was communication with the PREA Compliance Manager and other facility staff during the document review process, as needed. The additional documentation that was requested was provided prior to the site visit and as requested during the site visit.

The site visit was conducted June 27, 2017. A comprehensive tour was conducted by the Director of Operations and included all areas of the facility and outside grounds. Contact was made by telephone with a representative from the victim advocacy agency who verified the services of the agency to the facility as stated in a Memorandum of Understanding. During the comprehensive facility tour, the printed notifications of the PREA site visit were observed to be posted in the areas previously identified with the pictures that were sent earlier to this Auditor. Ten residents were interviewed and seven direct care staff members were interviewed that covered all three shifts. There were 10 specialized staff interviews conducted and included a contractor. The interviews with staff members indicated that they had received PREA training. An exit conference was held at the conclusion of the the site visit with the Director of Operations, Director of Compliance and a member of the facility's management team.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 6.1 and a host of facility PREA policies prohibit all forms of sexual abuse and sexual harassment and they outline the approach for preventing, detecting, and responding to such allegations. The Florida Department of Juvenile Justice (FDJJ) Policy 1919 serves as the overarching and comprehensive policy and all of the facility's PREA policies are aligned with FDJJ 1919 and the PREA Standards. The facility's PREA policies, the FDJJ PREA policy and other FDJJ policies outline the strategies for addressing the components of the PREA Standards and include the following: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review.

The policies contain definitions of the prohibited behaviors and address sanctions to be used when the PREA related policies are violated. The Director of Operations serves as the PREA Compliance Manager and his role was confirmed through the interview and a review of Policy 6.1 and the facility's organization chart. The Director of Operations is directly supervised by the person in the Executive Director position. During the interview, the Director of Operations stated that he has the time and the authority required to fulfill his PREA related duties; he also discussed the facility's efforts in achieving compliance. Interviews conducted with random staff also confirmed their awareness of the role of the Director of Operations as the PREA Compliance Manager.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The standard is not applicable; the facility does not contract with other facilities for the confinement of its residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The policies, 6.13 and FDJJ 1919, outline the considerations for staffing and provides guidance to staff in adhering to the contract required staffing ratios of 1:8 during the waking hours and 1:12 during the sleeping hours. The work schedules and obsevations during the comprehensive facility tour showed the adherence to the staffing ratios and the facility policy. The staffing plan provides for the staffing ratios to be met and the facility has a system that ensures adherence to the staffing plan. During the interview with the Director of Operations, there were discussions of the considerations for the development and maintenance of the staffing plan, including the identification of blind spots and security and program needs.

The policies provide that at least once a year a review of the staffing plan occurs. The annual Staffing Plan Assessment was completed by the FDJJ statewide PREA Coordinator in conjunction with the Director of Operations/PREA Compliance Manager and includes but is not limted to a review of the following: staffing plan; monitoring system; resources available and committed to ensure adherence to the staffing plan; and the occurrence of unannounced rounds. The form summarizing the review is signed and dated by both the Director of Operations and the FDJJ statewide PREA Coordinator.

During the comprehensive tour of the facility, observations were made of compliance with the staffing plan; work schedules were also reviewed. The policies provide for compliance to the staffing plan except during limited and exigent circumstances and that the the deviations be documented. The facility reports that the average daily number of residents during the past year is 29 and the average daily number of residents on which the current staffing plan was predicated is 30. The facility also reports that in the past 12 months there were no deviations from the staffing plan.

A review of documented unannounced rounds and the policies support that unannounced rounds are conducted by higher level and intermediate level staffs and are recorded in the log book as they occur. The unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment. The Program Manager, one of the staff members who conducts unannounced rounds, stated that his visits are unscheduled and he ensures that staff are not alerting other staff regarding the unannounced visits and only shares the occurrence of the rounds with the Director of Operations. He indicated that staff are aware of not alerting other staff when the unannounced rounds are being conducted. The policies support the practice that staff does not alert other staff when the PREA rounds are occurring.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 5.06 provide guidance to staff regarding searches and address the type of searches to be conducted. Cross-gender strip and cross-gender visual body cavity searches are prohibited at the facility. Cross-gender pat-down searches are not permitted, except in exigent circumstances. The interviews with direct care staff members, residents and Director of Operations and the policy confirmed that cross-gender searches are not conducted. According to the staff interviews and the staffing plan, a male is always present to conduct the regular searches. The facility has addressed the searching of transgender and intersex residents through an onsite review. The review included a presentation on working with transgender and intersex residents and conducting searches in a professional and respectful manner, consistent with security needs. The FDJJ will work in conjunction with contract facilities regarding any standardized practices for the searches of transgender and intersex residents.

The facility reports that there have been no type of cross-gender searches conducted during this audit period and there have been no transgender or intersex youth admitted during this audit period. Searches are conducted and are documented by staff, per policy. Policy 5.06 prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status; this information was also verified through random staff interviews. When the genital status of a resident is unknown, learning this information may be obtained from resident interview or would be part of a broader medical examination or review of medical records conducted by a medical practitioner.

The facility has implemented procedures, aligned with FDJJ 1919, that guides staff regarding procedures that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. The shower procedures are specific and are posted in the appropriate area of each dormitory. Random staff and resident interviews, observations of posted procedures confirmed the practices for residents being provided a reasonable amount of privacy. The bathroom procedures were explained during the comprehensive tour conducted by the Director of Operations and the Program Manager. Policy 6.15 and posted signs outside of the dormitories inform female staff that they must announce themselves upon entering the housing unit. According to staff and resident interviews, the opposite gender staff announce their presence verbally when entering their living areas.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 6.16, supported by FDJJ 1919, address securing support services for disabled residents. The AMIkids staff serve as language interperters as needed and an internal list is maintained that includes contact numbers and the language(s) that they may provide assistance. Resources have been identified for staff to access various interpreters and other support services, including services for the hearing impaired, intellectual disabilities, and based on the individual need of the resident. Facility staff may provide a resident a copy of the PREA information in the dominant languages of youth admitted to the facility, other than English.

Additional resources may be accessed through arrangements with Language Line Solutions, as needed. The policy provides that residents with disabilities and who are limited English proficient be provided with the support services that would enable the identified residents to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment. The facility reports that during the past 12 months there has not been a need for interpreters.

The random staff interviews support that the facility does not rely on resident interpreters, resident readers or any type of resident assistants for the provision of PREA information for another resident as required by the policies. Residents have not been used as interpreters, readers or in any way to provide interpretive services during this audit period. The resident handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also posted on the living units and in various areas of the facility.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 1.01, 1.02, FDJJ 1800, and FDJJ 1919 address hiring and promotion processes and decisions. The collective policies and interview with the Business Manager provide details regarding the hiring process, completion of background checks, and the grounds for termination. The policies are aligned with the requirements of the standard and provide that background checks occur and that child abuse registries are checked prior to employment and every five years thereafter. A review of a sample of personnel files and the interview with the Business Manager confirmed the practices. One of the pre-hire forms seeks information from applicants regarding previously related sexual misconduct allegations and convictions as observed by the Auditor and as explained by the Business Manager.

The policies prohibit hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor who may have contact with residents who has engaged in previous sexual misconduct. The interview confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee. The interview with the Business Manager supports the policy that staff has a continuing duty to report related misconduct and provide that omissions of such conduct or providing false information will be grounds for termination.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The camera system works in conjunction with direct staff supervision and cameras are strategically placed to assist staff in keeping residents safe from sexual abuse. There has been an upgrade to the camera system which includes the installation of additional equipment to provide more storage time as evidenced by the invoice reviewed for the updates conducted. The additional work to the system and the importance of its functions were explained by the Director of Operations during the comprehensive tour of the facility. The system can now store data for 30-40 days. There has been no expansion or modification to the building structure since the last PREA audit in 2014.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.21 and FDJJ 1919 and random staff interviews, provide that facility staff members are not responsible for conducting administrative or criminal investigations. FDJJ 1919 and Written Directive 3-05 from the Office of the Inspector General support that the Florida Department of Juvenile Justice Office of the Inspector General (OIG) is responsible for conducting administrative investigations. The Policies provide that the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse; and local law enforcement, Hillsborough County Sheriff's Department, is responsible for conducting investigations that are criminal in nature. The Director of Operations serves as the contact person with the Sheriff's Department regarding an investigation as determined through the interview and the review of documentation regarding contact with the Sheriff's Department and the OIG investigator. The FDJJ provides each facility written information regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011 that is to be shared with local law enforcement.

The facility has provided for victim services through a written Prison Rape Elimination Act Agreement with the Crisis Center of Tampa Bay. Victim assistance that will be provided include a forensic examination conducted by a qualified medical practitioner; an advocate to support the victim through the forensic examination and/or the investigatory interview; emotional support; crisis intervention; related and referral information; and access to the agency's hotline number. The Agreement also outlines the conditions of confidentiality. A telephone interview with a representative from the Crisis Center of Tampa Bay confirmed the content of the Agreement, applicable to other area juvenile facilities, and that treatment services provided to a victim will be free of charge to the victim. There was one allegation of sexual abuse which was against staff during this audit period; it was investigated by the Hillsborough Sheriff's Department. There was not a need for a forensic examination and a victim advocate was not requested or contacted through the hotline by the resident; however, the Therapist facilitated the resident calling his mother.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.22 and FDJJ 1919 and interviews with random staff and the Director of Operations provide that allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by trained investigators and sexual abuse allegations are referred for an investigation to the Hillsborough County Sheriff's Department and the Department of Children and Families is contacted. During the past 12 months there were a total of three allegations; one was administratively investigated by the FDJJ Office of Inspector General (OIG) with the findings of Unfounded; another one is still in progress by the OIG. One allegation of sexual abuse against staff was referred for criminal investigation to the Hillsborough County Sheriff's Department. A review of the report showed that the findings resulted in "no indication of sexual abuse-sexual molestation." The three allegations were reported to the appropriate authorities.

The policies direct staff to report all allegations of sexual harassment or sexual abuse to identified agencies and to document the reports. Staff members are aware of the policy requirements as verified through the interviews. The FDJJ and AMIkids websites provide policy and information respectively, for reporting allegations of sexual abuse. Reporting information is also posted in various areas of the facility, accessible to residents, staff and visitors. The OIG has policies and written directives governing investigations and the PREA information sheet regarding investigations is provided to each facility for sharing with law enforcement.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policies 6.31 and FDJJ 1919 address PREA related training for staff. The policies, training materials, staff interviews, and a review of training rosters document that the staff training occurs. All staff interviewed were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. Basic PREA training is provided to staff, as indicated by annual training logs and acknowledgement forms; refresher training is also provided for staff where indicated and was confirmed through staff interviews. The direct care, medical and mental health staff and contractor interviewed reported receiving the PREA training as required. The facility houses males and the training considers the needs of the population served. Documentation and interviews support that PREA training, refresher information and supplemental training are provided to staff.

All direct care staff interviewed verified that the general topics below were included in the training:
*Facility zero-tolerance and PREA related policies;
*Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;
*Resident's right to be free from sexual abuse and sexual harassment;
*The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;
*Dynamics of sexual abuse and sexual harassment in juvenile facilities;
*Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;
*How to avoid inappropriate relationships with residents;
*Common reactions of sexual abuse and sexual harassment juvenile victims;
*Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-comforming residents;
*Mandatory reporting; and,
*Relevant laws regarding the applicable age of consent.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.32 addresses volunteer and contractor training and in accordance with FDJJ 1919. Acknowledgement forms and the FDJJ training curriculum for volunteers and contractors were reviewed and documented that the training occurs. The training provided includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment. The interview with a contractor confirmed his understanding of the facility's zero-tolerance of sexual abuse and sexual harassment and how to report such complaints, allegations or incidents. The PREA training informs the contractors and volunteers of their role in reporting allegations of sexual abuse or sexual harassment. The contractors and volunteers are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services they provide as determined from the

training materials, acknowledgement forms, and the interview with a contractor.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.33 provides that all residents admitted receive information about the facility. PREA education is also included and involves directions to residents about how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. The resident handbook also provides information to residents on how to report allegations of sexual harassment and sexual abuse. The assigned staff who conducts PREA education with residents explained the process for ensuring that residents receive the information. The PREA related information is a part of the intake packet completed with each resident and residents sign an acknowledgement form confirming that they have participated in the PREA education provided. Interviews with the staff member and residents and a review of a sample of acknowledgement forms indicated that the PREA education sessions had occurred.

Although residents were informed about the meaning of PREA and related information, their rights and how to report allegations, they were not as informed regarding the victim advocacy services that are available to them through the Crisis Center of Tampa Bay. A corrective action was implemented through the Director of Operations. Specific information regarding advocacy services provided by the Crisis Center of Tampa Bay was reviewed with all the residents. More specific information regarding the services of the Crisis Center of Tampa Bay will be incorporated in the PREA education sessions moving forward. The refresher training for the residents was documented and based on the posted information regarding the advocacy services. The training description, contents, and rosters signed by each resident were forwarded to this auditor confirming the occurrence of the additional training. The PREA related information is provided to staff in policies, training and/or staff meetings.

The facility has the capability of providing the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the PREA related information posted in the living unit, and other areas. The facility has made prior arrangemens for the provision for interpretive and translation services and staff interviews confirmed that residents are not used as translators or readers for other residents. Facility and other AMIkids staff also provide support services to residents as needed and to ensure access to services that will provide disabled residents the opportunity to participate in PREA education sessions. The facility reports that 72 residents, admitted in the last 12 months, received comprehensive age-appropriate PREA education.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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According to Policies 6.34 and FDJJ 1919 and staff interviews, the facility staff members do not conduct investigations. Administrative investigations are conducted by the Office of the Inspector General (OIG) and criminal investigations are conducted by the Hillsborough County Sheriff's Department and/or the Department of Children and Families. FDJJ 1919 provides that OIG staff be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. The investigators have been trained in conducting allegations in the FDJJ settings. The Director of Operations is the primary contact regarding sexual abuse investigations conducted by the OIG, Sheriff's Department and/or the Department of Children and Families as evident through the review of correspondence and other documents.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policies 6.35 and FDJJ 1919 provide that medical and mental health staff members are required to receive the regular PREA training and the specialized training available online through the SkillPro training system provided by the Florida Department of Juvenile Justice. The mental health and medical staffs completed the general training that is provided for all staff members which is also available through the SkillPro training system, in addition to the specialized training. Forensic medical examinations will not be conducted by the facility's medical staff. A review of the training records and interviews with medical and mental health staffs revealed their completion of the specialized training.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.41 and FDJJ 1919 provide that all youth admitted to the facility are properly screened. Staff and resident interviews and a review of documentation confirmed that residents are screened for risk of victimization and abusiveness. This vulnerability screening is required to occur within 72 hours of admission, whether the youth is transferred from another facility or is a new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). The VSAB is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; the youth's self-identification; current charges and offense history; and intellectual or developmental disabilities. Resident interviews, a review of documentation and the interview with the Director of Treatment indicated that the VSAB is administered according to policy.

The VSAB is administered through asking questions; probing where needed; talking to parents or guardians; and reviewing court and related paperwork. Additional screening and assessment tools are used to obtain information to aid staff in meeting the individual needs of the residents. Interviews with residents indicated that residents are asked safety questions including their concern about their own safety. The policies provide for reassessments to be conducted as evident through the review of a sample reassessment and the interview with the Director of Treatment. The information from the risk screening is accessible to the Therapist, Case Manager and medical staff and the files were observed to be maintained in a confidential manner. The residents interviewed were able to identify specific areas that are asked of the resident during the administration of the VSAB.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.42 and FDJJ 1919 address this standard and provide guidance to staff regarding the information from the VSAB and other risk screening instruments and outline how the information is to be used. The information obtained through the administration of the screening instruments assists in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. A review of documentation and the interview with the Director of Treatment confirm the practice for the use of the information obtained from the VSAB.

Isolation is not used in this facility and there has not been a resident placed in isolation or controlled observation during this audit period due to concern for their safety from sexual abuse. Random staff interviews indicated that protective measures would be taken immediately if it was determined that a resident was at risk for imminent sexual abuse and protective measures included separating residents by placing in different dormitories or different beds in a dormitory; increase monitoring and heighten supervision; alert supervisor and other staff; and move or adjust the resident's bed within the dormitory.

Policies 6.42 and FDJJ 1919 prohibit placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The policies also prohibit staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. Facility and agency policies and interviews support that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis to ensure the resident's safety. The staff members are aware of the policies that would be implemented when there are transgender or intersex residents within the population. The resident's concern for his own safety is currently taken into account through responses obtained from the administration of the VSAB and as confirmed through resident interviews.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

Policies 6.51 and FDJJ 1919 address this standard and provide multiple internal ways a resident may report, including how he can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to the aforementioned incidents. Residents may report allegations of sexual abuse or sexual harassment by telephone, accessing the FDJJ and Crisis Center of Tampa Bay hotlines. The direct care staff interviews collectively revealed that they may also use the abuse hotline to privately report sexual abuse or sexual harassment of residents or talk directly to their supervisor, Director of Operations, or the Executive Director.

There are additional internal ways a resident may report, such as completing a grievance form; talk to any staff member; complete a form requesting to speak to a specific staff member; complete a sick call form; and third parties may report allegations either in writing or through the abuse hotline. Access to writing tools is provided for residents so that they are able to complete the forms. Information about reporting allegtions of sexual abuse and sexual harassment is also contained in the resident handbook and is posted in the dormitories and other areas of the facility. Resident and staff interviews revealed their awareness of the methods a resident may report allegations. Residents are not detained in the facility for civil immigration purposes.

Staff and residents are aware of policy and practice regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymously, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility and could report abuse to that person if needed. The residents were aware that third-party reports could be made and that reports could be made anonymously. Policies and staff interviews support that staff members are required to immediately document all verbal reports.

One of the allegations received for the facility during this audit period was done anonymously through the FDJJ abuse reporting hotline. The Incident/Complaint Report Form for this allegation shows the status of the investigation is "In Progress." The allegation of abuse made during this audit period was told to staff; the verbal report was documented and a written report was obtained from the resident as confirmed by the resident, Director of Operations and a review of the incident paperwork. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, staff meetings, and posted information.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 6.52 and the resident handbook provide that grievances regarding sexual abuse or sexual harassment may be completed and submitted at any time and may be placed in the locked grievance box. The resident is not required to handle an emergency grievance informally by attempting to resolve the situation with staff. During the past 12 months, there has not been a grievance submitted alleging sexual abuse. When a grievance is received regarding sexual abuse or sexual harassment, it is immediately provided to the Director of Operations/PREA Compliance Manager. The policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by the facility policy and FDJJ1919. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse or sexual harassment. The content of the grievance is reported and an investigation may be conducted by the FDJJ Office of Inspector General; Florida Department of Children and Families; or local law enforcement when the allegation is criminal in nature. The purpose of the submission of a PREA related grievance provides residents and staff another avenue for ensuring the reporting of allegations and provides management staff with the opportunity to protect the resident. There is no time limit for a resident to submit an emergency grievance alleging sexual abuse or sexual

harassment and there is a response from staff within 48 hours informing the resident of receipt of the grievance and that it has been referred for investigation.

Policies 6.52 and FDJJ 1919 provide staff with the required information for reporting sexual abuse and sexual harassment of residents. The facility and agency policies provide that a resident may be disciplined when it has been determined that a report alleging sexual abuse was not made in good faith. Residents understand that they will not be punished if a report is made in good faith, as determined through the interviews.

The residents and staff interviewed identified the grievance system as one of the methods that may be used to report allegations of sexual abuse or sexual harassment and the residents are aware of how grievances are handled regarding sexual abuse or sexual harassment. The residents have access to grievance forms, writing materials, and locked grievance boxes for depositing the completed grievance form, as determined through observations during the comprehensive tour and interviews with residents and staff. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment and that it will be forwarded for investigation.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.53 and FDJJ 1919 address the residents' access to outside confidential support services. The facility has a written agreement with the Crisis Center of Tampa Bay for the provision of forensic examinations, support, and other advocacy services. Contact information for the Crisis Center is posted in the facility and is contained in the resident handbook. The agreement lists the responsibilities of the Crisis Center as well as the responsibilities of facility staff. During the comprehensive tour of the facility, the posted information, grievance and sick call forms, and grievance and sick call boxes were observed.

The interview with the Director of Operations; review of the written agreement and policy; and posted information support that advocacy services have been put in place. However, residents were not familiar with the specific services that would be provided by the Crisis Center if they ever needed them. A corrective action was implemented and all residents have received a PREA education refresher session and subsequently specific information will be covered in the regular PREA education sessions. All resident interviews and the interview with the Director of Operations and observations during the comprehensive facility tour support that residents are provided confidential access to an attorney or other legal representative and reasonable access to their parents/legal guardian. All residents were aware of how they could communicate with their parents/legal guardian and that attorneys and court workers could visit the facility. Residents also confirmed that they had someone on the outside to report allegations of sexual abuse if they needed to. Residents were aware of the visitation and telephone days and times.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.54 and FDJJ 1919 address third-party reporting and interviews revealed that residents are aware that third-party reporting of sexual abuse or sexual harassment can be done. All residents interviewed stated that they knew someone who did not work at the facility that they could report to regarding allegations of sexual abuse. Staff interviews revealed their knowledge of third-party reporting and that they can receive allegations from third parties. Information regarding reporting is provided through observed postings that are located in areas of the facility that are accessible to visitors, residents and staff members. The FDJJ website contains information regarding third-party reporting of allegations of sexual abuse.

Interviews with direct care staff revealed that they are aware of their obligation to receive and submit reported allegations from others. Staff members are also aware that they are to document all verbal reports and promptly, in accordance with facility policy. Interviews with residents confirmed their knowledge of what third-party reporting means. The residents shared the methods within the facility in which residents may make third-party reports which include the grievance system, tell staff, and utilize the sexual abuse reporting hotline.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.61 and FDJJ 1919 address the standard and provide that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws. Reporting according to the mandatory laws and the applicable policies was evident through document review regarding the reporting of the three allegations and the documentation of the subsequent investigations conducted by the OIG and the Hillsborough County Sheriff's Department. The administrative investigation conducted by OIG was closed as "Unfounded" and the other one is in progress. The investigation conducted by the Sheriff's Department concluded there was, "no indication of sexual abuse-sexual molestation."

Allegations of sexual abuse or sexual harassment are to be reported immediately to the Central Communications Center (CCC). Policy 6.61 requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment or behavior that contributed to an incident or retaliation. The policy also prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. The CCC will make appropriate notification to senior DJJ management who will make notification to management overseeing the facility where the alleged incident occurred. Policies 6.61 and FDJJ 1919 require the notification of the alleged victim's parents or legal guardian. If the resident is under Department of Children and Families (DCF) custody, the DCF Case Worker is to be notified and if applicable, the attorney of record will be notified of the allegation within 14 days of receipt of the allegation. A review of documentation revealed that the applicable notifications were made.

Interviews with direct care, mental health and medical staff revealed that they are aware of the requirements regarding their reporting duties and understand that they are mandated reporters and must immediately report all allegations of sexual abuse and complete a written follow-up report. All direct care staff members interviewed provided information that was aligned with the reporting requirements and that the expectation is that reports are documented immediately. The facility staff members are also required by policy to report allegations that were made anonymously or by a third-party. According to interviews with the Clinical Director and Nurse and facility policy, the residents are informed at the initiation of services of the limitations of confidentiality and their duty to report. The interview with the Director of Operations was aligned with the facility policies.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The combined policies, 6.62 and FDJJ 1919, require staff to protect the residents through immediately implementing protective measures. The summarized interviews of the direct care staff and the Director of Operations revealed that protective measures include: separating the residents involved; alerting supervisor and other staff; and closer supervision. The Director of Operations indicated that the expectation is that actions to protect a resident would be implemented immediately. Isolation is not used in this facility.

The residents are provided information on how to report through the resident handbook and posted information. Residents indicated that during the intake process, their feelings about their safety are part of the inquiries by staff and are explored by staff during informal treatment team meetings with their Case Manager. A review of documentation indicated that risk assessments are conducted periodically during the resident's stay in the facility. The facility reports that during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.62 and FDJJ 1919, direct that the Executive Director or designee, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred.

Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The identified management staff member must also notify the Central Communications Center to report the incident for an investigation. Policy requires the Executive Director or designee to notify the facility head where the alleged incident occurred. The facility reports that during this audit period, there has not been a report about an incident of abuse occurring while the resident was confined in another facility. The management staff is aware of the policy and the required duties regarding reporting to other confinement facilities and the requirement that allegations received from other facilities must be investigated.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.64 and FDJJ 1919 require that any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. The Policy directs the first responder to request that the alleged victim does not wash; brush their teeth; change clothes; wash or do anything that may destroy evidence. Interviews with staff members who would serve as first responders and a non-security staff revealed that they are aware of their duties. The policies instruct non-security staff who may act as a first responder to request that physical evidence be preserved and to contact direct care staff for assistance. During this audit period there was not an incident or allegation of sexual abuse that required the implementation of the first responder duties; preserving or maintaining evidence; or the performance of a forensic examination.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a written institutional plan, Coordinated Response, which is an outline for the actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staff. This coordinated response to an incident of sexual abuse is also aligned with Policies 6.64 and FDJJ 1919. Staff members interviewed were familiar with their role regarding the response to an allegation of sexual abuse, aligned with the policies and the written response plan.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not maintain any collective bargaining agreements, per policy 6.66 and the interview with the Director of Operations.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.67 and FDJJ 1919 address protection to residents and staff from retaliation. Policy 6.67 provide that the Department of Operations has the responsibility for retaliation monitoring under the leadership of the Director of Operations, assisted by the shift supervisors. An interview with the Director of Operations and a review of retaliation monitoring forms for the 90-day period following an allegation of sexual abuse demonstrated the practice of retaliation monitoring. The interview and the documentation revealed that he understands the responsibility of observing whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation.

The interview also revealed some of the things that would be considered in detecting retaliation, as outlined in Policies. The retaliation forms showed where the Director of Operations monitored subsequent rule violation reports for the resident to ensure that they were not initiated for retaliatory reasons and through the inquiry determined they were not. The Director of Operations identified additional items that would be considered to determine the occurrence of retaliation include changes in a resident's housing; changes in behavior of staff and/or resident; and write-ups that staff may receive.

Retaliation monitoring was conducted as the monitoring forms document for the resident who reported the allegation of sexual abuse. During the interview, the resident revealed that he felt safe in the facility and that he felt protected from any revenge. He further added that staff did what they had to do and that he had no grudges. The Director of Operations and the retaliation monitoring forms revealed that the monitoring occurred for at least 90 days and that no occurrence of retaliation was identified.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. Segregated housing or isolation is not used at this facility.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.71 and FDJJ 1919, staff interviews, and a review of documentation provide that administrative investigations are conducted by the FDJJ Office of the Inspector General and criminal investigations are conducted the Hillsborough County Sheriff's Department. Sustained allegations as a result of a criminal investigation will be referred for prosecution. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. There was one alleged incident that was investigated by the Hillsborough County Sheriff's Department which was concluded as "no indication of sexual abuse-sexual molestation."

The policies direct facility staff to cooperate with investigations and the documentation reviewed indicates such. Policy FDJJ 1919 also provides that an investigation is not terminated because the source recants the allegation. The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings. The OIG Investigators receive training on the related Department policies; PREA; and conducting investigations. The investigative reports include descriptions and investigative facts and findings.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policies, 6.72 and FDJJ 1919, and practice of the Office of Inspector General, impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.73 and FDJJ 1919 address this standard and includes that the victim is informed when the investigation is completed and informed of the outcome of the investigation. During the past 12 months there was one allegation of sexual abuse made by a resident against a staff member which was investigated by the Hillsborough County Sheriff's Department. The document of the conclusion of the investigation, with the resident's signature and dates, show that the information was provided to the resident.

Interviews with the Director of Operations and the resident who made the allegation of sexual abuse confirmed that the resident was kept abreast of what was going on during the investigation and was also notified of the outcome of the investigation. The written notification regarding the completion of the investigation was a letter from the Sheriff's Department which contained the identification of the investigative entity and stated the findings. The Director of Operations remains abreast of investigations by serving as the primary contact person with the Hillsborough County Sheriff's Department and the OIG.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.76 and FDJJ 1919 provide for disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance and supportive policies. The facility reports that during this audit period, no staff member violated facility or agency policy regarding sexual abuse or sexual harassment. The allegation made by a resident against a staff member was not substantiated as the result of an investigation conducted by the Hillsborough County Sheriff's Department.

The policies collectively provide that disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff. Additionally, policies provide that terminations or resignations by staff that would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. The interviews with the Business Manager and the Director of Operations revealed the facility's personnel practices and their knowledge of the related policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.77 and FDJJ 1919 address this standard, including requiring that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. It also provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies. The training and communication with volunteers/contractors and the interview with a contractor support that the facility takes measures to provide volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited. An interview with the contractor and review of documentation confirmed the occurrence of the PREA training and he is aware of the zero-tolerance policy and how to report allegations of sexual abuse or sexual harassment of residents. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.78 and FDJJ 1919 address requiring an administrative process for dealing with violations, including resident-on-resident sexual abuse. The facility's formal process holds the residents accountable for their actions. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Policy 6.78 provides that sexual activity between residents is prohibited and indicates that court or administrative processes and sanctions occur after determination that the sexual activity was coerced. Residents will be disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact. Isolation is not used in this facility.

The polices provide that anyone reporting in good faith will be immune from any civil or criminal liability. During the past 12 months there have been no administrative findings or criminal findings of guilt regarding resident-on-resident sexual abuse. Policies 6.78 and FDJJ 1919 and interviews with mental health and medical staffs support that counseling or other interventions are offered to address and correct the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after an incident.

The interview with the resident who made an allegation of sexual abuse and documentation confirmed that there was a follow-up meeting with mental health and medical staffs after the allegation of sexual abuse was made. The interview with the Therapist and a review of documented encounters by mental health and medical with the resident also confirmed the follow-up meetings and there are documented subsequent status checks with the Therapist. Observations, interview with resident, and a review of documentation do not indicate that the resident was denied access to participation in the behavior management system, education services, or other program activities.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.81 and FDJJ 1919 address this standard, including providing for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with medical and mental health staff and a review of documentation confirmed the practice of residents being promptly seen by treatment staff. The practice is that residents are generally seen by medical and mental health staffs on the same day of admission as part of the intake process. A resident alleged sexual abuse approximately two weeks after an alleged incident of being touched by staff while clothed; documentation and interviews show that he was seen by mental health staff on the same night he made the allegation and by the nurse the following morning.

Policy supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and other staff, based on their need to know. A review of files show that medical and mental health staff members maintain documentation of the services they provide to the residents. Medical and mental health staffs discussed their knowledge of informed consent, in accordance with policy. Policy 6.81 provide that signed consent would be obtained for residents 18 years and older prior to the healthcare personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. No information regarding a resident's sexual abuse history is to be shared with other staff unless it is required for security and management decisions.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.82 and FDJJ 1919; staff interviews; and a review of documented practices revealed that emergency medical care and crisis intervention services will be provided by medical and mental health staff as required. Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate. A review of documentation shows that medical and mental health staff members maintain secondary materials that document services to residents and these staff are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policy and understood by the medical and mental health staffs that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation.

The interviews with the Nurse and the Director of Treatment revealed that residents have access to unimpeded access to emergency services and that medical and mental health services are determined according to the professional judgment of the practitioner. Policies and procedures and a documented coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. Staff interviews and documentation reviewed confirmed their awareness of the policies and the methods to implement for protecting residents. The interviews with the Nurse and the Director of Treatment confirmed that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis.

The observations of the interactions and delivery of services by medical and mental health practitioners, review of records, and staff interviews confirmed that unimpeded services are available to a victim of sexual abuse. It was determined from staff interviews, review of policy and related documents, and observations that medical and mental health staff maintain secondary materials regarding medical and mental health encounters and the treatment services provided; including allegations of sexual abuse. It was determined through the interviews with medical and mental health staff; interviews with other staff and residents; review of the written response plan and other documentation; and observations that immediate medical treatment and crisis intervention services will be provided to an alleged victim of sexual abuse. The interview with the resident who alleged sexual abuse confirmed the provision of the coordinated services as indicated.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.83 and FDJJ 1919 address this standard. Interviews with the Nurse and Director of Treatment confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. The interviews collectively indicated that on-going services would be provided for sexual abuse victims and abusers and would include follow-up medical and mental health services and referrals as needed; follow doctor's orders; provide therapy; and work cooperatively with the victim advocacy agency, Crisis Center of Tampa Bay. The Nurse confirmed that resident victims will be offered tests for sexually transmitted infections as medically appropriate. The written agreement with the Crisis Center of Tampa Bay also provides for referral services.

All treatment services will be provided at no cost to the victim.The staff interviews; document review; and observations revealed that medical and mental health services are consistent with the community level of care. Policies, interviews and document review also support that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or a juvenile facility. The resident who reported the allegation of sexual abuse did not require medical services as indicated by the resident, Therapist and a review of documentation; however, the resident did receive the initial meetings with a Therapist and Nurse after the allegation was made.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 6.86 and FDJJ 1919 provide for an incident review to be conducted within 30 days of the completion of an investigation in accordance with the standard. Policy FDJJ 1919 address the areas to be assessed by the incident review team and identifies the positions that comprise the team. The Director of Operations/PREA Compliance Manager is knowledgeable of the purpose of the incident review process. During this audit period, there was one investigation completed by the Hillsborough County Sheriff's Department that alleged sexual abuse. However the findings of the investigation were, "no indication of sexual abuse-sexual molestation" which was determined to be the equivalent of Unfounded. An incident review team meeting was not required; however, the staff was provided refresher training regarding boundaries where residents are concerned. A form has been developed for the incident review process, including allowing for the assessment of the situation and inclusion of recommendations. The PREA Compliance Manager will also serve as a member of the incident review team.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

A review of the FDJJ 1919 policy confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for FDJJ facilities and contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ). Florida DJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with directives by FDJJ and the facility policies and FDJJ aggregates the sexual abuse data which culminates into an annual report. The agency/facility will provide DOJ with data as requested.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 and facility policy provide guidance regarding this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. Policy provides that an annual report be prepared that will provide an assessment of the agency's progress in addressing sexual misconduct.

The annual report is approved as required. A review of the annual report reflects that that the agency has compared the results of annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. Observed improvements in processes are indicative of continuous improvement regarding PREA initiatives. The annual report is posted on the website of the Florida Department of Juvenile Justice (FDJJ) and is accessible to the public. There are no personal identifiers on the annual report. The report may also be accessed through the facility's website and a link which leads to the FDJJ website and the annual report.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 and facility policy provide that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless statutes require otherwise. According to the policies, the aggregated sexual abuse data from all facilities will be readily available to the public through the FDJJ website; the practice is that the report is posted on the agency's website as determined through observation. The review of the annual report verified that there are no personal identifiers, as required.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Shirley L. Turner July 31, 2017

Auditor Signature Date