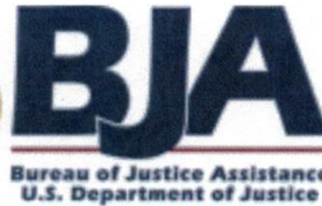
PREA AUDIT: AUDITOR'S SUMMARY REPORT JUVENILE FACILITIES



Name of Facility: AMIkids Big Cypress			
Physical Address: 25959 Turner River Road, Ochopee, FL 34141			
Date report submitted: February 24, 2016			
Auditor information: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: February 2, 2016			
Facility Information			
Facility Mailing Address: Same as Physical Address			
Telephone Number: 239-695-1001			
The Facility is:	☐ Military	☐ County	☐ Federal
	☐ Private for profit	☐ Municipal	☐ State
	☒ Private not for profit		
Facility Type:	☐ Detention	☐ Correction	☒ Other: Residential
Name of PREA Compliance Manager: Marvin Ferrell		**Title:**	**Executive Director**
Email Address: bigcypress-ed@amikids.org		**Telephone Number:**	**239-695-1001**
Agency Information			
Name of Agency: AMIkids Big Cypress, Inc.			
Governing Authority or Parent Agency:			
Physical Address: 5915 Benjamin Center Drive, Tampa, FL 33634			
Mailing Address: Same as Above			
Telephone Number: 813-887-3300			
Agency Chief Executive Officer			
Name: O. B. Stander		**Title:**	**CEO/President**
Email Address: obs@amikids.org		**Telephone Number:**	**813-887-3300**
Agency Wide PREA Coordinator			
Name: Wendell Watson		**Title:**	**Regional Director**
Email Address: WLW@amikids.org		**Telephone Number:**	**321-863-1497**

AUDIT FINDINGS

NARRATIVE:

The AMIkids Big Cypress residential program is located on the Big Cypress National Preserve in Ochopee, Florida and is operated through a contract with the Florida Department of Juvenile Justice (DJJ). The facility serves low and moderate risk male juvenile offenders between the ages of 13 and 18. The length of stay is three to nine months and the facility capacity is 30. Risk and needs assessments are completed on each resident in order to develop individualized plans that combine behavior modification, education and treatment. This comprehensive approach addresses mental health issues; addiction; family issues; academic problems; and legal consequences.

Medical services are provided on-site by a full-time Registered Nurse who is the Lead Nurse and there is a part-time Registered Nurse. The contract physician visits the facility at least weekly and is on-call. Mental health services are provided by on-site staff through the Director of Treatment, two full-time therapists and one contract therapist. A contract psychiatrist visits the facility every two weeks. Each resident participate in individual and group counseling; residents have the opportunity to learn to develop skills to resolve issues regarding anger management, substance abuse, alcohol abuse; and other mental health issues.

Education services include academic and remedial work, GED preparation, and Post GED courses. The education services also include the teaching of employability skills and independent living skills. Community activities such as service projects, group work projects and incentive trips are available to each resident as he progresses through the program. Through experiential education the facility provides opportunities for residents to participate in life experiences that they may not have been exposed to if it was not for this program. The facility offers a vocational program in construction which is supported by an accreditation organization, National Center for Construction & Education Research (NCCER). A vocational program is also offered in food service, where residents may earn ServSafe food handler certification from the National Restaurant Association. The facility uses a point system as a part of behavior management techniques. The number of points a resident earns is based on their participation and behavior throughout each day. Achieving a certain number of points for the level the resident is on affords him the opportunity to participate in the Bid Store, special programs and special activities on campus.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There are six primary buildings that make up the Big Cypress program: administration; dorm 1; dorm 2; education; kitchen/dining area; and vocation. The administrative building consists of a reception area, administrative offices; conference room; and the medical clinic. The dormitories have aesthetically screened porches and ramps leading into them which represent the work completed by the residents under staff supervision. The set-up of the dorms and strategically placed staff afford residents a reasonable amount of privacy during showers within their housing units. The education

building has a screened front porch area where staff members are stationed, three classrooms, and two bathrooms. A shelter is attached to the education building that serves as a physical fitness area which contains related equipment. The kitchen building comprises ample space for the cooking and dining areas. The vocation building is a large structure located beyond the group of other buildings. The grounds also contain a greenhouse, several picnic tables which the residents built, and storage sheds. A "Bikes for Tykes" portable structure is on the grounds and is used by the residents and staff in repairing bikes that are later donated to children and adults in need. The grounds provide ample space for various outside large muscle exercises, recreation and other activities.

Thirty-five staff members who may have contact with residents are currently employed at the facility. Seventy-six youth were admitted to the facility during the past 12 months. Seventy-six residents have been admitted to the facility in the past 12 months.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. Telephone conversations were held with the Executive Director and other AMIkids staff and the DJJ statewide PREA Coordinator to review the PREA audit processes. The facility policies and supporting documentation were uploaded to a flash drive, which was received by the Auditor prior to the on-site visit. After reviewing the information, notes were sent to staff to seek clarity of information and to note the additional documents needed. In response to the issues noted, additional information was provided and discussed during the site visit.

The on-site visit was conducted February 2, 2016. An entrance meeting was held and a comprehensive tour of the facility was conducted by a resident accompanied by the Executive Director and the Director of Case Management from another AMIkids facility, Melbourne Center for Personal Growth. During the tour, staff members were observed to be actively engaged in supervising and interacting with the residents. There were 18 residents at the facility on the date of the audit and interviews were conducted with randomly selected residents. Interviews were conducted with direct care staff from all shifts and staff identified in the specialized areas. The staff members interviewed were knowledgeable of the related policies and their duties and responsibilities as they relate to PREA compliance. At the conclusion of the audit, a summary of the findings were provided in a close-out meeting with the Executive Director and the Director of Case Management from the Melbourne Center for Personal Growth, who provided technical support to the Big Cypress program.

Number of Standards Exceeded: 0

Number of Standards Met: 39

Number of Standards Not Met: 0

Number of Standards Not Applicable: 2

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

AMIkids Big Cypress has developed a collection of policies and procedures that directly address the PREA standards. The policies are aligned and used interchangeably with the overarching Florida Department of Juvenile Justice PREA policy and procedures, FDJJ 1919. The policies and procedures provide guidelines for implementing the facility's and the agency's approach to complying with the requirements of the PREA standards including zero-tolerance toward all forms of sexual abuse and sexual harassment. Policy 6.11 contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. The Executive Director, who manages the facility, has been identified as the PREA Compliance Manager and he reports to the Regional Director.

Standard 115.312 Contract 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)

X Standard Not Applicable

Auditor Comments:

The facility does not contract with other agencies for the confinement of residents.

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.13 states the required staff ratio of 1:10 during the waking hours and 1:12 during the sleeping hours and further states that the plan is predicated on a population of 30 residents. An annual staffing plan assessment had been conducted, as required, by the DJJ statewide

PREA Coordinator. The facility has also developed forms for conducting internal annual staffing assessments. The Policy states that when the required ratios are not met due to limited and discrete exigent circumstances, the deviation from the plan will be documented in the facility logbook.

The Policy identifies the management staff responsible for conducting unannounced rounds to deter sexual abuse. The staff interviewed stated that the unannounced visits occur on all shifts, as evidenced by documentation, and that staff members are knowledgeable of and practice not alerting other staff when such visits occur. The facility reports that there have been no deviations from the staffing plan that is based on the current contract requirements, during the past 12 months. An interview with the Executive Director revealed how the work schedules are reviewed to ensure that the ratios are met. He also shared that the facility is currently involved in implementing the hiring process to increase the number of direct care staff to meet the staffing ratio requirement of the standard. PREA drills are conducted based on scenarios that include the completion of a document that considers steps that were taken to protect the victim; steps to preserve evidence; staff ratio at the scene of the incident; proper notifications; etc.

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 Comments:

According to Policy 6.15, staff members are prohibited from searching a transgender or intersex resident to determine the resident's genital status and no type searches have occurred in the past 12 months. Staff interviews revealed that they are knowledgeable of this requirement. The Policy also prohibits cross-gender strip and visual body cavity searches and cross-gender pat-down searches which staff and resident interviews validated as practice. The viewing of residents by opposite gender staff while they are showering, changing clothes, and performing bodily functions is not permitted, unless there are exigent circumstances.

According the Policy, signs posted and interviews with staff and residents, female staff members announce themselves upon entering the dorms or other areas where residents may be performing bodily functions. Staff and resident interviews support that female staff members do not provide supervision to residents during shower time or when they are using the toilet. Supervision practices provide residents with a reasonable amount of privacy and ensure no cross gender viewing. Training documentation shows and interviews confirm that staff has received training on conducting searches in a professional and respectful manner, including searches of transgender and intersex residents.

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 Comments:

Policy 6.16 addresses the tenets of this standard including providing that the facility will not rely on resident interpreters, resident readers or any kind of resident assistance except when a delay in obtaining interpreter services would jeopardize a resident's safety, performance of first responder duties, or an investigation. In such cases, it must be documented by staff in the logbook according to policy. The staff interviews and documentation show that the facility has the capability to provide residents with support services from staff and by contracting with individuals from a list of certified providers. In the past 12 months, there have been no instances where residents have been used as interpreters, readers or any other type assistants as verified in staff interviews.

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 Comments:

Policies 6.17 and FDJJ 1919 address the hiring and promotion process including the requirement of obtaining background checks on all employees and require consideration of any incidents of sexual harassment in hiring or promotions or in obtaining services of a contractor. The Policies prohibit hiring or promoting anyone who has engaged in sexual abuse in prison, jail, juvenile facility, or other institution; convicted of engaging or attempting to engage in sexual activity by force, threat or coercion; or has been adjudicated to have engaged in such behavior. Applicants and employees are asked about previous misconduct and sign the acknowledgment form, Self-Declaration of Sexual Abuse/Sexual Harassment, as to whether or not any of the actions have occurred. A review of documentation in personnel files and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted. The Policies and reviewed documented practices and interviews support that criminal background checks are conducted every five years and that omissions about misconduct or providing false information are grounds for termination. The facility reports that during the past 12 months, all individuals hired have received background checks.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

The facility uses direct and engaged supervision in ensuring the safety of residents. A camera system was installed in 2013 to enhance staffs' supervision and monitoring of the residents. There has not been a substantial expansion or modification to the facility since August 20, 2012.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

According to Policies 6.21 and FDJJ 1919 and staff interviews, the facility is not responsible for conducting administrative or criminal investigations. The DJJ Office of the Inspector General (OIG) is responsible for conducting administrative investigations; the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse and they are also contacted; and the local law enforcement agency, Collier County Sheriff's Office, is responsible for conducting criminal investigations. All of the agencies follow the requirements of the standards regarding administrative and criminal investigations.

Document review included a draft Memorandum of Understanding (MOU) between the facility and the Collier County Sheriff's Office for the investigation of alleged sexual abuse or attempted sexual abuse occurring at the facility. The draft MOU states that the Sheriff's Office will follow uniform evidence protocols that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. It further states that the Sheriff's Office, as appropriate will utilize protocols of the most recent edition of "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents or similar protocols developed after 2011. Information regarding the administration and location of forensic examinations is also included in the draft document, which is still in the process of being finalized with all the appropriate signatures. The DJJ provides each facility with an information sheet that is to be shared with local law enforcement which provides information regarding protocols related to the investigation of allegations that are criminal in nature.

Policy 6.21 provide that victim advocacy services will be provided and at no cost to the victim. The facility has a MOU with a rape crisis center, Project Help, Inc. When requested, a qualified staff member from Project Help will provide support services that include provision for a forensic examination; accompany the victim through the forensic medical examination process; access to 24/7 rape crisis hotline, staffed by certified victim advocates; counseling; information and referral services; and follow-up support. The provision of services to be provided was confirmed through interviews, including a representative from Project Help, Inc. There has not been a need for a forensic medical examination during this audit period. Information is posted in the dorms and other areas of the facility regarding the reporting of sexual abuse and sexual harassment. In the dining room, there is a poster for Project Help that provides the information about services and how to make contact and it has an added convenience of tear-away contact numbers at the bottom of the poster so that anyone (resident, staff or visitor) may take the number with them when they leave the area.

Standard 115. 322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.22 and FDJJ 1919 identify the agencies that will conduct the criminal and administrative investigations. Policy instructs the facility staff to cooperate with the OIG investigations and ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. During the past 12 months, there was one allegation of sexual abuse that received an administrative investigation. It was determined that the allegations were Unsubstantiated, according to the reviewed reports and staff interviews.

The policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation, as required by the standard, is available to the public on the DJJ website. Information regarding reporting sexual abuse is included in the packet provided to the residents' parents/legal guardians. All random staff interviews confirmed that allegations of sexual abuse and sexual harassment are documented.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.31 provides for the PREA training outlined in the standard. The staff training covers the areas referenced in the standard and includes the facility's and agency's zero-tolerance policies. A review of the training documentation and interviews with staff confirms that the initial training is provided and refresher training is provided annually and as needed. All staff receives the PREA training and the training is tailored to meet the needs of the population served. A review of a sample of staff training records and staff interviews support that initial training and refresher training occurs. The training is a combination of the Florida DJJ training provided online through Skill-Pro and in-house training.

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)

Auditor Comments:

Policies 6.32 and FDJJ 1919 contain the requirements regarding the training of volunteers and contractors who have contact with residents. The training covers their responsibilities regarding the zero-tolerance of sexual assault and sexual harassment and how to report any allegations or incidents. All vendors visiting the facility are required to read and sign the Vendor Acknowledgement Statement that includes prohibited behavior, including sexual contact or sexual conversation with residents. The vendors are also required to read the Prison Rape Elimination Act Acknowledgement form which includes an overview of PREA, definitions of sexual abuse, and how to report allegations.

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)

Auditor Comments:

Policy 6.33 requires that residents receive information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. During the intake process residents are provided an age-appropriate education session regarding PREA. A signed acknowledgement statement by the resident of his having received the training is kept

in the case management file. Residents transferring from another facility will also receive the PREA education during the intake process as verified by staff. Acknowledgement statements were reviewed in the files; the intake staff articulated how she ensures that each admission receives the PREA education; and all residents interviewed stated their participation in PREA education. The facility reports that all 76 admissions during this audit period participated in education sessions. A new resident was admitted during the on-site visit and the admission process was observed. Staff took care to put the resident at ease and explain the rules of the facility and what each step would contain at each step of the intake process. There were coordinated efforts and cooperation by intake, case management, medical, mental health, and direct care staffs in service delivery. PREA education is provided to residents during the intake process.

PREA education would also involve providing the information through accessible formats if needed for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled. Support services may be provided through local certified providers; identified facility staff who speak the prominent languages of residents who are limited English proficient; and other facility staff. Information regarding PREA and emotional support services for victims are posted throughout the facility and flyers about the rape crisis center are also maintained on the desk in the reception area and all of the posted information is available to residents, staff and visitors. The Student Handbook contains information about abuse and how to report it.

The interviews with the residents revealed a general uncertainty regarding the specific services that would be provided to a victim of sexual abuse from the rape crisis center, although information was posted. The facility had been in communication with the rape crisis center regarding services but finalized the MOU just prior to the on-site visit and had not yet provided detailed information about specific services to the residents. A corrective action was implemented to provide updated training to residents regarding the services that will be available and confidentiality practices of Project Help, Inc. The subsequent receipt of a training roster where residents wrote their names and further discussion with staff support that the updated training has been provided. The flyer from Project Help will continue to be reviewed in the PREA education sessions and given to the resident as it was done during an intake that was conducted during the on-site visit.

Standard 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

FDJJ 1919 states that staff in the OIG will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Training is provided to investigative staff regarding conducting investigations in the DJJ settings. The draft MOU,

between the facility and the Collier County Sheriff's Office states that the Sherriff's Office agrees to comply with the PREA standards regarding the investigative process and will follow the prescribed protocols. The document has been reviewed by the involved parties. The DJJ also provides facilities with an information sheet for local law enforcement investigators regarding protocols for investigations that are criminal in nature.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

Policy 6.35 addresses the elements of this standard. The medical and mental health staff members received the on-line specialized training through Skill-Pro, provided by DJJ. The training documentation was reviewed and the interviews with medical and mental health staff members indicated that they have received the general and specialized PREA training. Forensic medical examinations are not conducted at the facility.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

Policies 2.04/05/06 and 6.41 address this standard. Included in the facility's classification process is the use of the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) instrument. It is completed on each resident and is an objective instrument required by DJJ. Staff and resident interviews and a review of completed VSABs confirm that screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being conducted. Policy 6.41 requires that the VSAB is completed within 72 hours of admissions; however, the staff and resident interviews and a review of a sample of documents revealed that the practice is that it is completed on the day of admission. Residents are reclassified, where indicated, during their stay in the program. The facility reports that 76 residents, all that were admitted during this audit period, were involved in the classification process and a VSAB was completed.

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 Comments:

Policy 6.42 provides that information gleaned from the classification process, including application of the VSAB, is used to guide the decisions regarding bed, education, work and other program assignments for residents. The facility's policy addresses isolation in general and includes the PREA standards' requirements; however, the practice of the facility and the agency is that isolation is not used. The facility does not have an isolation room or segregated housing. The Policy does say that isolating any resident will be done only as a last resort when less restrictive measures are inadequate to keep the resident or others safe. Policy 6.42 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The Policy, which staff members are familiar with, prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. There have been no residents isolated in the last 12 months because he or she was at risk of sexual victimization.

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 Comments:

According to Policy 6.51, interviews and observations, there are several internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation(s) that lead to abuse. A resident may talk to any staff member; put the information in writing and give it to any staff member; the DJJ and the rape crisis center abuse hotline numbers are available and may be called by residents; and third parties may report allegations to the facility or use the hotline numbers. The Policy directs staff to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties; staff interviews reflected knowledge of this mandate. Interviews with staff and Policy afford staff with methods to privately report allegations through the use of the abuse hotline and talking to management staff; the methods are covered in staff training and PREA policies are also reviewed.

Staff interviews were also aligned with the Policy requirement of calling in allegations of sexual abuse and sexual harassment to the DJJ Central Communications Center within two hours and documenting the report within eight hours. The resident grievance system may also

be used to report allegations of sexual abuse or sexual harassment by completing a grievance form and placing it in the locked grievance box. Through observations and resident interviews it was determined that residents have access to writing tools to complete a grievance form.

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Standard 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

According to Policy 6.52 and staff interviews, the facility considers resident grievances regarding sexual abuse to be an allegation of sexual abuse and when such a complaint is received, the reporting policies and procedures are initiated. The Policy states that allegations of sexual harassment grievances will be addressed through the facility's grievance system. The facility makes the current grievance process another method for internal reporting of allegations of sexual harassment and a resident may report allegations of sexual abuse using the grievance system. The facility staff does not investigate allegations of sexual abuse or sexual harassment; once the alert is made to staff through the grievance system, the allegations are reported and the OIG or appropriate investigative entity will follow-up regarding the investigation. The facility does not have administrative procedures to address grievances regarding sexual abuse due to them being considered an allegation of sexual abuse and addressed through reporting and investigation policies. There have been no grievances alleging sexual abuse filed in the past 12 months.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.53 supports the residents having access to outside victim advocacy services. A MOU has been obtained with the local rape crisis center. Project Help, Inc. Posters are displayed regarding the services and contact information. Flyers are also maintained at the front desk in the reception area, available to staff, visitors and also residents. The details of the MOU were recently completed and a written document was developed. The details of the services had not yet been thoroughly reviewed with the residents prior to the site visit. A corrective action was

implemented after the site visit where a PREA education session was conducted with all residents receiving a review of the specific services and the confidentiality practices of the facility and Project Help, based on the written materials received from the agency. A roster of the residents, where they had written their names, was submitted to the auditor with additional discussion with staff regarding the PREA training. While on site it was discussed how the specific information would be incorporated in the PREA education session that is provided with each resident during the intake process. Interviews with staff stated that reasonable privacy is given to residents regarding reporting allegations of sexual abuse and would be provided during any instance that a resident contacts Project Help.

Policy 6.53 provides for reasonable and confidential access to attorneys and other court or agency staff. The Policy also provide for the residents to have reasonable access to parents or legal guardians. All of the residents interviewed could verbalize how they are able to receive visitors and make phone calls and confirmed that contact may occur with attorneys or other legal representatives and with their parents, legal guardians or someone else. Visitation information is also provided in the Student Handbook.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.54 provides information regarding third-party reporting of sexual abuse. Pamphlets regarding reporting sexual abuse and sexual harassment are available at the reception desk in the administration building and other related information is posted throughout the facility. The sign-in book for vendors visiting or performing a service at the facility contains acknowledgement forms to be signed indicating they have received information regarding conduct expectations, overview of PREA, and how to report allegations of sexual abuse or sexual harassment. Posters containing reporting information are displayed in various areas of the facility, including areas that are accessible to the public.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policies 6.61 and FDJJ 1919 and the Florida Administrative Code Rule 63F-11 address this standard. All staff members are required to report any allegation of sexual misconduct or resident-on-resident sexual activity to the Central Communications Center. The Policy states that staff members are prohibited from revealing any related information to anyone other than is necessary. The Policy requires that staff members are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment; and retaliation against residents or staff who report any incidents, staff neglect, or violation of responsibilities that may have contributed to an incident or retaliation. A review of the incident/investigation reports and staff interviews revealed that staff members are aware of the requirement regarding their reporting duties and understand that they are mandated reporters.

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 Comments:

Policy 6.62 addresses this standard and provides steps to take when staff learns that a resident is subject to substantial risk of imminent sexual abuse. The staff is instructed to take immediate action to protect the resident, such as make dorm, classroom, work, and other program re-assignments. There have been no actions in the last 12 months where the facility took any of these actions due to a resident being in 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 Comments:

Policy 6.63 requires that upon receiving an allegation that a resident was sexually abused while confined in another facility, the Executive Director or his designee will notify the head of that facility as soon as possible but no later than 72 hours and the appropriate investigative agency, which begins with the call to the Central Communication Center. The Policy also requires that the notification be documented within 72 hours of receiving the allegation. The OIG operations and FDJJ policy ensure that allegations received from other agencies or

facilities are investigated in accordance with the PREA standards. The facility reports that during this audit period, there has not been an allegation of sexual abuse occurring to a resident while he was in another facility. The interview with the Executive Director revealed his knowledge of the Policies and how to implement the procedures.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policy 6.64 outlines the first responder duties and responses which are generally to separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim and alleged abuser do not take any action that would destroy physical evidence. Initial training and refresher training was conducted with staff through a combination of online statewide DJJ courses and in-house training courses. The Policy directs that if the employee first responder is not direct care staff, the responder requests that physical evidence is preserved and direct care staff should be notified. Staff interviews revealed that they are aware of the steps to take if they are the first responder. There has been one allegation of sexual abuse or sexual harassment within the last 12 months, which was investigated by the FDJJ and was determined to be Unsubstantiated. The allegations were reported through a survey and did not require direct intervention from security or non-security staff. The staff interviews confirmed that they are knowledgeable of their duties as a first responder.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

The coordinated response is incorporated in the facility's Policy 6.65 and is aligned with the requirements of FDJJ 1919. The facility's sexual abuse response plan has been developed in checklist format and includes the coordinated actions for staffs to take that include first responders, medical and mental health practitioners, and management staff. Interviews with staff support that an institutional plan in response to an incident of sexual abuse has been developed and that they are familiar with their roles. Drills are also conducted by staff using various PREA related scenarios and they are documented, using the specific form, for management review.

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 Comments:

This standard is not applicable. The facility does not maintain any collective bargaining agreements.

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

According to Policy 6.67, the Operations Department Shift Supervisors, under the supervision of the Director of Operations, will be directly responsible for ensuring all residents and staff members who report sexual abuse or sexual harassment are protected from any retaliation occurring. The Director of Operations is responsible for reporting any possible retaliation to the Executive Director. Staff members found to have engaged in retaliation will receive disciplinary action up to and including termination. Residents engaging in retaliation will receive disciplinary work details and loss of privileges. If the retaliation conduct is identified, the monitoring would be conducted for no less than 90 days and longer if indicated. The form, PREA Retaliation Monitoring Report, has been created to document the monitoring activities.

There has been one allegation of sexual abuse within the last 12 months and the retaliation monitoring found no incidents of retaliation occurring. Interviews with staff and a review of the Administrative Review Report revealed that the allegations were Unsubstantiated. The retaliation monitor interview revealed that the monitoring considers a review of resident point cards, interactions between staff and resident, and behavior of staff and residents and he was able to discuss remedies that could be taken if retaliation is suspected or determined.

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Although the practice is that segregation or isolation is not used at the facility, Policy 3.62 includes that a resident may be isolated from others only when less restrictive measures are inadequate and until other arrangements can be made. The facility does not have segregated or isolation rooms. Staff interviews revealed that there is no practice of isolation; however, removing a resident temporarily from the other residents until he can be placed in another program or his return to regular placement is safe, may require the resident remaining in an area with staff away from other residents, such as the medical clinic. The Policy and staff interviews support that the rights of the resident such as education services and large muscle exercise will not be violated. During this audit period, there has not been a situation where a resident has been temporarily removed from the general population due to his need for protection from sexual abuse, sexual harassment or retaliation.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

X 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 Comments:

Policies 6.71 and FDJJ 1919 address this standard. Administrative investigations are conducted by the DJJ Office of Inspector General (OIG) and criminal investigations are conducted by the local law enforcement agency, Collier County Sheriff's Office. The Florida Department of Children and Families (DCF) are also called when there is an allegation of sexual abuse. Both Policies direct facility staff to cooperate with the investigations. An investigation is not terminated solely because the source of the allegation recants the allegation. This is evident through staff interviews and the review of investigation reports. The investigation by DCF and a DJJ administrative review were conducted although the allegations were recounted and an apology provided by the resident. The allegations were also referred to the Sheriff's Office; however, it was determined that they would not conduct an investigation. FDJJ 1919, staff interview and the draft MOU, as well as the understanding with the Collier County Sheriff's Office also ensure that allegations of conduct that appear to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards 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 Comments:

Policies 6.72 and FDJJ address this standard. The OIG, responsible for administrative investigations, imposes a standard of a preponderance of the evidence for determining whether allegations are substantiated. The draft MOU document with the Collier County Sheriff's Office states that the Sheriff's Office will follow the appropriate protocols as required by the standards. The Department of Children and Families is a state agency with a responsibility of investigating allegations of child abuse.

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 Comments:

Policy 6.73 and FDJJ 1919 address this standard. The facility's policy provides for staff to notify the resident when an investigation has been completed and that the notification be documented. There is documentation indicating that the resident was verbally informed of the results of the investigation. During the course of the investigation of the one allegation of abuse reported during this audit period, the resident recanted the allegations made on a survey and apologized for his actions.

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 Comments:

Policy 6.76 provides for disciplinary sanctions for staff to be up to and including dismissal for violation of the facility's zero-tolerance policies against sexual abuse and sexual harassment. In the past 12 months, no staff member has been terminated or has resigned for

violating the facility's PREA policies. Personnel policies and FDJJ 1919 provide that 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.

During the past 12 months, no staff member has been disciplined for violation of agency sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies. Agency policy provide that terminations or resignations by staff who would have been terminated if not for the resignation, are reported to local law enforcement if the situation appeared to be criminal in nature and to relevant licensing bodies. The staff interviewed revealed his knowledge of the personnel policies, procedures and practices.

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 Comments:

Policies 6.77 and FDJJ 1919 address the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. They will be reported to local law enforcement and to relevant licensing bodies and would be prohibited from having contact with residents. Sexual activity between residents and between residents and volunteers and contracted personnel is prohibited. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative agency for allegations of sexual abuse. During this audit period, there have been no allegations of sexual assault 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 Comments:

Policy 6.78 addresses this standard. Any resident found in violation of the facility's zero tolerance policy regarding sexual abuse, sexual assault, sexual misconduct or sexual harassment against another resident will receive disciplinary sanctions after a formal administrative process. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Sexual activity between residents is prohibited and administrative or court processes and sanctions occur

when it has been determined that the sexual activity was coerced. The Policy also states that the facility may discipline a resident for sexual contact with staff only upon finding that the staff did not consent to such contact.

The Policy addresses a resident receiving counseling or other interventions to address the underlying reasons or motivations for the resident-on-resident abuse; this information is also provided in the Student Handbook. There has been no incident of resident-on-resident sexual abuse in the past 12 months. The facility does not use isolation as a disciplinary sanction. Interviews with mental health and medical staffs support that counseling or other interventions will be 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 staff members interviewed stated that any type interventions used would not be dependent on the resident's participation in the behavior management system, education or other programs or services. FDJJ 1919 provides that anyone reporting in good faith shall be exempt 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 that occurred at the facility.

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 Comments:

Policy 6.81 provides that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse during an intake screening will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed confirmed awareness of the policy and the requirements of the standard and stated that their process affords the practice of the meetings to occur sooner. Staff also reported that where indicated, specific services may be provided through a contract specialist. The facility and staff interviews report that no residents disclosed prior victimization or previously being a perpetrator during this audit period during the medical or mental health screening.

Policy 6.81 supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners. A review of files showed that medical and mental health staff members maintain documentation of the services they provide to the residents. Interviews and the review of files show that staffs are knowledgeable of the importance of documenting and there would not be issues in documenting the delivery of services related to mental health or medical screenings regarding a resident's history of sexual abuse. Medical and mental health staffs discussed their knowledge of informed consent regarding how informed consent is used for residents18 years old and older; consent forms are contained in the medical files.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

FDJJ 1919 address the sections of this standard. The Policies require that treatment services to every victim be provided at no cost to the victim and verified by staff and the representative from the rape crisis center. According to the Policies, services will be provided regardless of whether or not the victim names the abuser or cooperates with any investigation due to the incident. Staff interviews confirmed that the nature and scope of the medical and mental health services are determined by medical and mental health practitioners based on their professional judgment. Staff interviews, as well as a review of records and documented practices revealed that crisis intervention services will be documented and maintained by medical and mental health staff as required.

Observations of files show that medical and mental health staff members maintain secondary materials that document services to residents and in an incident of sexual abuse the requirement of the standards will be met as demonstrated through interviews and the files reviewed. Mental health and medical staffs articulated that a victim would receive timely and unimpeded access to emergency medical treatment and crisis intervention services. The staff interviews supported that a victim would be provided medically appropriate information and care based on professionally accepted standards of care.

Standard 115.383 Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

Policy 6.83 addresses ongoing medical and mental health care for sexual abuse victims and abusers. It also provides for the appropriate tests to be provided. The facility will obtain a mental health evaluation within 60 days of learning of resident-on-resident abuse and offer treatment deemed appropriate by a contract mental health practitioner. The referral process for the treatment will be documented and was explained during the mental health staff interview. Mental health and medical staffs relayed through interviews their awareness of the Policy and how it would be implemented and the services provided. Additional interchanges with staff, document review, and observations of responses to residents revealed that medical and mental health services are consistent with the community level of care.

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 Comments:

Policies 6.86 and FDJJ 1919 state that the sexual abuse incident review team will assess the incident within 30 days of the completion of an investigation unless it determines that the allegation was Unfounded. According to the policies and staff interview, the sexual abuse incident review team includes upper-level management; supervisors; medical or mental health practitioner; and allow for input from investigators. Representatives from DJJ also participate on the team. The meetings are documented using the Sexual Abuse Incident Review Report form.

There have not been any criminal investigations conducted at the facility in the last 12 months. One administrative investigation was conducted during this audit period and it was determined that the allegations were Unsubstantiated. The Policies and the incident review report process allows for the inclusion of written findings and recommendations and the completed report to be provided to the Facility Administrator, who also serves as the PREA Compliance Manager. The Policies and an interview with one of the identified team members revealed that he was knowledgeable of the role of the team. A review of documentation revealed that incident reviews are conducted.

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 Comments:

FDJJ 1919 and interviews with staff confirmed that DJJ collects incident-based, uniform and aggregated data regarding allegations of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Policy requires the collection of accurate, uniform data for every allegation of sexual assault. The agency provides the U. S. Department of Justice (DOJ) with data as requested. The format used for DJJ facilities and its contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the DOJ and the information is provided as requested. The agency maintains and collects various types of identified data and related documents regarding sexual abuse incidents. FDJJ aggregates the sexual abuse data annually that culminates into an annual report, which has been reviewed by this Auditor.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

FDJJ 1919 addresses this standard. The statewide PREA Coordinator along with other agency management staff reviews the collected and aggregated data 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. The Policy also states that an annual report will be prepared that will provide an assessment of the agency's progress in addressing sexual misconduct. A review of the current documentation and interviews with facility and agency staffs confirm this practice and the comparative review to the previous report is also confirmed. The annual report is approved as required.

It is obvious from staff interviews, observations, and document review that the agency has compared the results of the annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. The annual report has been reviewed by this Auditor and the report is accessible to the public through the agency's website. The report does not contain any personal identifying information.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

X☐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 Comments:

According FDJJ 1919, it is required that data is collected and securely retained for 10 years after the initial collection date, unless statutes require otherwise. The aggregated PREA data from all facilities including contractors is reviewed, all personal identifiers are removed, and the report is made readily available to the public through the agency's website. A review of the reports and interviews with the facility staff and the DJJ statewide PREA Coordinator confirmed the practice.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

Shirley L. Turner

February 24. 2016

Auditor Signature Date