A PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Duval Academy				
Physical Address: 7500 Ricker Road, Jacksonville, FL 32244				
Date report submitted: April 20, 2015				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
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Telephone number: 678-895-2829				
Date of facility visit: March 30, 2015				
Facility Information				
Facility Mailing Address: 7500 Ricker Road, Jacksonville, FL 32244				
Telephone Number: (352) 840-8240				
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: Erica Crosby			**Title:**	Asst. Facility Admin.
Email Address: Erica.Crosby@youthservices.com			**Telephone Number:**	(904) 777-0100
Agency Information				
Name of Agency: Youth Services International, Inc.				
Governing Authority or Parent Agency: NA				
Physical Address: 6000 Cattle Ridge Dr., Suite 200, Sarasota, FL 34232				
Mailing Address: Same as Above				
Telephone Number: (941) 953-9199				
Agency Chief Executive Officer				
Name: James Slattery			**Title:**	President & Chief Executive Officer
Email Address: Jim.Slattery@ysii.com			**Telephone Number:**	(941) 9533-9199
Agency Wide PREA Coordinator				
Name: Jesse Williams			**Title:**	PREA Coordinator
Email Address: Jesse.Williams@youthservices.com			**Telephone Number:**	(941) 704-8796

AUDIT FINDINGS

NARRATIVE:

The Duval Academy is a 28-bed residential facility located in Jacksonville, Florida. It houses male juvenile offenders, ranging from ages 14 to 18, in a moderate custody level environment. The facility is operated by Youth Services International, Inc. (YSI) through a contract with the Florida Department of Juvenile Justice (FDJJ). The length of stay is six to nine months and residents participate in a daily schedule that includes education/vocational classes; case management services; health care services; and recreation. Over 88 residents have been admitted to the facility during the past 12 months.

The number of staff positions at the facility that may have contact with the residents is 39. Medical services are provided on-site by two Registered Nurses, with one serving as the Lead Nurse. The contract physician visits the facility on a weekly basis. Mental health services are provided by the Clinical Director, two Therapists, and a contract psychiatrist who visits the facility every other week. Education services are provided on-site through the Duval County School Board. Case management services are provided by two Case Managers and a Transition Specialist. Youth Counselors, with the support of Shift Supervisors, provide direction and oversight of residents during their involvement in activities and services.

An individualized treatment plan is completed for each resident and a formal monthly staffing of each resident's treatment plan is conducted. The formal staffing is a meeting with the resident, case manager and the treatment team. Additionally, residents are involved in informal reviews with their Case Managers. The formal staffing includes but is not limited to a review of the objectives for each problem noted on the treatment plan; assessment of progress regarding the level system; review of health concerns; and updating of discharge plans.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The entrance to the building contains the control room, a large foyer and administrative offices. Beyond the administrative section of the building is the Pavilion, a dayroom where residents may gather to watch movies, play video games, and engage in other activities. Additional offices, a conference room, group room, kitchen, dining room, and classrooms are located in and beyond the Pavilion area. The facility also has an area that serves as the print shop where residents, in addition to other activities, make postcards and design t-shirts. Housing space for the residents consists of two living units, A Mod and B Mod which hold 14 residents each. The Mods have a bathroom that affords residents a reasonable amount of privacy while they shower, change clothes and perform bodily functions.

PREA related information is prominently posted throughout the facility, accessible to the residents and the public. Brochures are posted in English, Creole and Spanish, representative of the general make-up of the population of the facility. Residents have the opportunity to complete community service hours in the facility which have been assigned by the courts.

SUMMARY OF AUDIT FINDINGS:

Prior to the on-site audit visit, a conference call to discuss the audit process was held with the Facility Administrator and other YSI staff and the PREA Coordinator for the Florida Department of Juvenile Justice. The notifications of the on-site audit were later posted in various parts of the facility prior to the site visit. Photographs were taken of the locations where the notices had been posted and the photographs were electronically sent to the Auditor. The Pre-Audit Questionnaire, policies and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. After reviewing the information on the flash drive, a follow-up call was made to the facility's PREA Compliance Manager to discuss data and for clarification of information. Additional information was provided or clarified and minor corrective actions were implemented prior to the site visit as requested.

The on-site audit was conducted March 30, 2015. A comprehensive tour of the facility was provided. This Auditor observed staff members directly supervising and interacting with residents. The interviews conducted included random staff from all shifts, specialized staff, contract and volunteer staff, and residents. PREA file folders were set up in a very neat and organized manner that contained supplemental documentation. A close-out meeting was held at the conclusion of the on-site audit and a summary of the audit findings was provided to facility management, PREA Compliance Manager, and YSI corporate office staff.

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.

☐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 3.19 contains strategies and implementation directions for facility compliance with the requirements of the PREA standards. The Policy provides for zero- tolerance toward all forms of sexual abuse and sexual harassment. Additionally, it contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. The facilities PREA related policies and practices are aligned with the Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919).

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)

☒ Standard Not Applicable

Auditor Comments:

The facility does not contract with other facilities for the confinement of 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)

Auditor Comments:

Policy 3.19 provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse and refers to the staffing assignments per the current contract. The operational work schedules and a hold-over system are implemented to maintain the required contracted staff ratios and the parent agency and FDJJ will address the contractual issues regarding the PREA staffing requirements. Policy 3.19 states that the staffing plan will be assessed as deemed necessary but at least annually. A documented Staffing Plan Assessment has been conducted.

Unannounced rounds of the facility for the maintenance of a safe environment are conducted and documented by intermediate and higher level staff. The Policy and facility's practice prohibit staff from alerting other staff while the unannounced rounds are being conducted. Staff interviews and a review of documentation confirmed the practice of unannounced rounds being conducted.

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:

Policy 3.19 provides instructions to staff regarding searches. Cross-gender pat-down searches, cross-gender strip searches and cross-gender visual body cavity searches of residents are prohibited, except in exigent circumstances or when performed by medical practitioners. In the event of any occurrence, documentation of the situation is required. Staff interviews revealed that the facility's general practice is that no cross-gender searches occur. All of the residents interviewed stated that they have not been searched by a female staff member during their stay at the facility.

The facility provides for residents to shower, perform bodily functions, and change clothes without being observed by staff of the opposite gender. Policy 3.19 states that staff shall not search a transgender or intersex resident to determine the resident's genital status and all staff interviewed were aware of this. The Policy directs staff to ask a transgender or intersex resident which gender they would prefer to conduct the search and any related cross-gender searches are to be documented.

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 3.19 reveals that support services are provided for residents with disabilities and residents who are limited English proficient so that they may benefit from and participate in PREA education. Resident education materials are accessible in languages other than English and the facility has a list of staff members who will provide interpretation services.

Policy 3.19 states that the facility will not rely on resident interpreters or resident readers to provide information to other residents. The Policy provides for the use of outside resources and the services of the education and mental health units. A Memorandum of Understanding exists between the facility and the Duval County School Board for the provision of support services. A review of the documentation and staff interviews reinforced that residents will not be used as interpreters or readers to assist other residents.

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:

Policy 3.19 and FDJJ 1919 provide for background checks on all employees, contractors and volunteers through a process that meets the requirements of the standard which is used statewide. Related documentation and staff interviews revealed that prior to the hiring of an employee or contractor or the use of a volunteer's services, background checks are conducted. The Policies require that criminal background checks be conducted every five years on employees and on contractors who may have contact with residents. Interviews and review of documentation support the Policies.

Standard 115.318 Upgrades to Facilities and Technology

☐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)

☒ Standard Not Applicable

Auditor Comments:

This standard is not applicable. The facility reports that there has not been a substantial expansion or modification to the facility and the camera system has not been updated during the time period since August 20, 2012.

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)

Auditor Comments:

Policy 3.19 and FDJJ 1919 state that staff will cooperate in investigations conducted by the FDJJ Office of the Inspector General (OIG). The OIG is responsible for administrative investigations and investigations are conducted by the Florida Department of Children and Families (DCF) and local law enforcement. According to Policy 3.19, forensic medical examinations will be completed at no financial cost to the victim.

The facility has a Memorandum of Understanding with University of Florida/First Coast Child Protection Team. The advocacy agency will provide forensic exams; counseling services; support planning for treatment services; staff training; and other assistance. The Team Coordinator was on-site for an interview during the audit and confirmed the services to be provided to the facility.

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 Comments:

Policy 3.19 and FDJJ 1919 requires staff report all allegations of sexual abuse and sexual harassment. The facility reports no allegations during this audit period. The facility posts related information regarding reporting allegations of sexual abuse and sexual harassment in areas that are accessible to the public. The DJJ website contains information regarding the referral of allegations for investigations of sexual abuse.

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)

Auditor Comments:

Policy 3.19 and FDJJ 1919 provide for the PREA training of all staff. Staff members have received the DJJ training and the facility has conducted refresher training in the primary areas addressed in the standards. Documentation of staff participating in training is maintained and staff interviews confirmed that DJJ and in-house training occurs.

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:

Policy 3.19 contains information regarding the training of volunteers and contractors who have contact with residents. A review of documentation and interviews with staff, a volunteer, and a contractor support that the training occurs.

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 3.19 provides for all residents to receive PREA education. A review of documentation and interviews with residents and staff confirmed that resident education is provided. Residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility will provide support services in accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled through identified facility staff and other resources. Support services will be provided to residents as outlined in a Memorandum of Understanding between the facility and the Duval County School Board.

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)

Auditor Comments:

FDJJ 1919 states that investigators 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.

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)

Auditor Comments:

Policy 3.19 addresses PREA training for medical and mental health staff. A review of documentation and staff interviews confirmed the specialized training received by medical and mental health staff. Forensic medical examinations are not conducted by the facility medical staff.

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 Comments:

The initial risk screening is conducted during the intake process. Policy 3.19 and staff interviews provide for residents to receive reassessments within the first 30 days and periodically during the resident's stay in the facility. A review of documentation and staff and resident interviews confirmed that the risk screening is being conducted on each admission to the facility.

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 3.19 prohibits the facility from placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. The Policy states that housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. Policy 3.19 also prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of the likelihood of being sexually abusive.

The facility reports that during this audit period there have been no residents placed in isolation because of being at risk for victimization. Policy 3.19 provides that residents may be isolated from others only as a last resort when less restrictive measures are inadequate and until other arrangements can be made to keep the resident safe. Where isolation may be used, Policy 3.19 provides that residents receive the required services.

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:

Policy 3.19 provides for internal ways a resident may report allegations. A "Speak Out Form" may be completed where the resident states what he would like to discuss and identifies the staff member he would like to talk to; complete a grievance form; talk to any staff member; and third parties may report allegations to staff. The grievance and other written requests may be placed in a locked box. PREA related information is posted in various locations. Residents are provided access to a telephone to report allegations or incidents of sexual abuse and sexual harassment through the identified hotline numbers.

Staff members are aware of their responsibility to report any allegations or suspicions of sexual abuse or sexual harassment, as confirmed through interviews. Staff members are also aware of their responsibility to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties as stated in Policy 3.19 and FDJJ 1919. Staff members are directed to immediately document verbal reports.

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 Comments:

Residents may put a completed grievance form in the grievance box. Residents are not required to use an informal grievance process regarding allegations of sexual abuse and sexual harassment. The facility considers an emergency grievance as a resident's allegation of an incident. When one is received, Policy 3.19 provides for the implementation of the procedures for reporting allegations of sexual abuse and sexual harassment.

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 Comments:

Policy 3.19 requires the facility to provide the residents with access to outside victim advocacy services. The facility has provided documentation of the existence of a Memorandum of Understanding (MOU) with the University of Florida/First Coast Child Protection Team. The results of an on-site interview with the Team Coordinator supported the services to be provided as stated in the MOU.

Visitation is held at the facility at least weekly where residents may see their parents/guardians and the residents are allowed to make at least one weekly telephone call. Attorneys or other legal representation may visit residents at the facility in a setting conducive to confidentiality.

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 Comments:

Policy 3.19 provides guidelines regarding third-party reporting. Information about reporting incidents of sexual abuse is posted in the facility, accessible to residents and the public. Staff and resident interviews confirmed that the facility has a method for third-party reporting. The YSI website contains a link to the DJJ website which provides information on how to report resident sexual abuse or sexual harassment.

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 Comments:

Policy 3.19 and Florida Statute address staff and agency reporting duties. Staff should immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment; retaliation against residents or staff who report any incidents; or any staff neglect or violation of responsibilities that may contribute to an incident or retaliation. Policy 3.19 prohibits staff from sharing information regarding sexual abuse other than as needed to make treatment, investigation, and other security and management decisions. Staff interviews revealed their knowledge of their duties as 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:

According to Policy 3.19, when a staff member learns that a resident is subject to substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident. The facility reports that there have been no incidents in the last 12 months where any action was taken due to a resident being in substantial risk of imminent sexual abuse. During interviews, staff could verbalize protective measures that may be taken when a resident is at substantial risk.

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:

According to Policy 3.19, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Facility Administrator (FA) will notify the Central Communications Center (CCC) of the allegation within two hours. The Policy also provides that the FA will notify the facility of which the allegation was made, no later than 24 hours. The facility reports that there were no allegations that a resident was abused while confined at another facility.

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 Comments:

Policy 3.19 contains the information and directions regarding first responder duties and responses. There has not been an allegation by a resident regarding sexual abuse during this audit period.

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 Comments:

The facility has a written Coordinated Response Plan. A review of training records and interviews with staff supported the staff's knowledge of their responsibilities. The Plan outlines the actions to be taken among staff including first responders, leadership, medical and mental health in response to an incident of sexual abuse.

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)

☒ Standard Not Applicable

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)

☒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 3.19 addresses protection against retaliation for residents and staff who report allegations of sexual abuse or sexual harassment and reportedly, monitoring for retaliation is ongoing. Staff has been identified and given the responsibility of monitoring for possible retaliation. The facility reports that no incidents of retaliation have occurred during the past 12 months.

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 Comments:

Policy 3.19 provides that if there is any use of segregated housing or isolation, it is used as a last resort and that the resident is afforded access to the required program and services provided by the facility. Staff interviews revealed that isolation is not used as a practice in 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 Comments:

Policy 3.19 and FDJJ 1919 address this standard. Administrative investigations are conducted by OIG and criminal investigations are conducted by DCF and local law enforcement. Both Policies direct facility staff to cooperate with the OIG investigations. The Policies provide for substantiated allegations of conduct that appear to be criminal to be 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:

FDJJ 1919 and Policy 3.19 support that a standard of the preponderance of the evidence is used for determining if 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 Comments:

Policy 3.19 and FDJJ 1919 provide for notifying residents following an investigation of whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Policies require that all notifications or attempted notifications be documented.

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 3.19 and FDJJ 1919 provide for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. Both Policies require that staff terminations or resignations by staff that would have been terminated for violating the PREA Policies, be reported to local law enforcement and to relevant licensing bodies. No staff has been terminated or has resigned, during this audit period, for violating PREA related policies during this audit period.

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:

According to Policy 3.19, the contractor or volunteer who engages in sexual abuse will have no contact with residents and will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The Policy requires that remedial measures be taken and prohibits future contact with residents in the case of any other violation of the PREA related policies. The facility reports that during the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

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 3.19 provides for a resident who engages in resident-on-resident sexual abuse to be placed in a DJJ Juvenile Detention Center. The resident will receive the required court hearings and a determination will be made regarding the subsequent placement.

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 3.19 states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be referred for a follow-up meeting with a medical or mental health practitioner within 24 hours of the screening. The related staff interviews and supporting documentation confirmed awareness of the policy and that medical or mental health follow-ups occur well within the stated timeframe.

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 Comments:

Policy 3.19 provides for timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse. According to the Policy and staff interviews, the nature and scope of the services are determined by medical and mental health practitioners based on their professional judgment. Staff interviews and Policy 3.19 provide for emergency medical and mental health services to be provided at no financial cost to the victim and whether or not the abuser is named.

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 Comments:

Policy 3.29 provides that ongoing medical and mental health care for sexual abuse victims will be provided. It also provides for medical and mental health evaluations and appropriate treatment and follow-up services as referred to in the standard. Policy 3.19, staff interviews and observations agree that the medical and mental health services provided 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:

Policy 3.29 and DJJ 1919 provide guidelines concerning the incident review team, including its duties, responsibilities and participants regarding conducting incident reviews. The incident review team has been identified and interviews revealed an understanding of the purpose of the process.

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:

According to Policy, the facility reports data to FDJJ on a monthly basis. Additionally, Policy 3.19 and FDJJ 1919 state that there is the collection of accurate, uniform data for every allegation of sexual assault. The FDJJ has developed a data collection instrument that includes the required data.

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 Comments:

Policy 3.19 and FDJJ 1919 address this standard. The Policies require the review of data for corrective action towards improving the effectiveness of the prevention, protection and response policies, practices, and training regarding sexual abuse and sexual harassment.

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 Comments:

Policies 3.19 and FDJJ 1919 requires data is collected and securely retained for 10 years. The aggregated PREA data is reviewed, all personal identifiers are removed, and the information is posted on the FDJJ website.

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 — April 20, 2015

Auditor Signature — Date