Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report March 12, 2019

Auditor Information

Name: Cheryl M. Anderson	**Email:** thechandegroup@gmail.com
Company Name: Correctional Management and Communications Group, LLC	
Mailing Address: Post Office Box 502	**City, State, Zip:** Blythewood, SC 29016
Telephone: 803-240-1209	**Date of Facility Visit:** February 25-26, 2019

Agency Information

Name of Agency TrueCore Behavioral Solutions, LLC		**Governing Authority or Parent Agency** *(If Applicable)* Florida Department of Juvenile Justice	
Physical Address: 6302 Benjamin Road, Suite 400		**City, State, Zip:** Tampa, FL 33634	
Mailing Address: Same as above		**City, State, Zip:** Same as above	
Telephone: (813) 514-6275		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency mission: Empowering individuals, families, and communities to discover their true potential.			
Agency Website with PREA Information: https://truecorebehavioral.com/prison-rape-elimination-act-prea/			

Agency Chief Executive Officer

Name: Steven Tomlin	**Title:** Chief Executive Officer & President
Email: steven.tomlin@truecorevehavioral.com	**Telephone:** 813-514-6275 ext. 237

Agency-Wide PREA Coordinator	
Name: Bobbi Pohlman-Rodgers	**Title:** Sr. Director of JJDPA/PREA Compliance
Email: bobbi.pohlman@truecorebehavioral.com	**Telephone:** 954-818-5131
PREA Coordinator Reports to: Sr. Vice President: Peter Plant	**Number of Compliance Managers who report to the PREA Coordinator** 33

Facility Information

Name of Facility:	Okeechobee Intensive Halfway House			
Physical Address:	7200 Highway 441 North, Okeechobee, Florida, 34972			
Mailing Address (if different than above):	Same as above			
Telephone Number:	863-763-2174			
The Facility Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☐ Correction	☐ Intake	☒ Other: Treatment

Facility Mission: Empowering individuals, families, and communities to discover their true potential.

Facility Website with PREA Information: https://truecorebehavioral.com/prison-rape-elimination-act-prea/

Is this facility accredited by any other organization? ☒ Yes ☐ No

Facility Administrator/Superintendent	
Name: Luis Torres	**Title:** Facility Administrator
Email: luis.torres@truecorebehavioral.com	**Telephone:** 863-763-2174

Facility PREA Compliance Manager	
Name: Orville Wallen	**Title:** Superintendent
Email: orville.wallen@truecorebehavioral.com	**Telephone**: 863-763-2174 ext. 201

Facility Health Service Administrator			
Name: Dr. Rothenberg		**Title:** Designated Health Authority	
Email: l.rothenberg@att.net		**Telephone:** 561-315-7929	
Facility Characteristics			
Designated Facility Capacity: 30		**Current Population of Facility:** 30	
Number of residents admitted to facility during the past 12 months			24
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			24
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			24
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	13-18		
Average length of stay or time under supervision:			6-9 months
Facility Security Level:			Non-Secure
Resident Custody Levels:			Commitment
Number of staff currently employed by the facility who may have contact with residents:			35
Number of staff hired by the facility during the past 12 months who may have contact with residents:			18
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			3
Physical Plant			
Number of Buildings: 2		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:		0	
Number of Open Bay/Dorm Housing Units:		3	
Number of Segregation Cells (Administrative and Disciplinary:		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):			
The facility is equipped with a video surveillance system which includes 12 cameras. The monitors are located in the Master Control room in the facility gate-house. Cameras are also monitored from the Superintendent and Facility Administrator's laptop computer. The monitoring data will be maintained for at least 30 days or until review of data is complete, whichever occurs first.			
Medical			
Type of Medical Facility:		In-house clinic	
Forensic sexual assault medical exams are conducted at:		Raulerson Hospital	
Other			
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:			3
Number of investigators the agency currently employs to investigate allegations of sexual abuse:			0

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Okeechobee Intensive Halfway House is located in Okeechobee, Florida and is operated by TrueCore Behavioral Solutions, LLC through a contract with Florida Department of Juvenile Justice (FDJJ). The onsite audit phase of the Prison Rape Elimination Act (PREA) audit was conducted on February 25-26, 2019 by Cheryl Anderson, a certified U. S. Department of Justice PREA Auditor. The facility's initial PREA audit was completed with a written report in April 2016. The current audit was attained and assigned to the Auditor by Correctional Management and Communications Group, LLC of Minneola, Florida.

The Okeechobee Intensive Halfway House (OIHH) is a program located on a large campus made up of three distinct program units. The campus is under the leadership of the Superintendent. The day-to-day operations of each program unit is under the direct management of the Facility Administrator and the Assistant Facility Administrator. Residents in each unit are provided services that include medical, mental health; education; case management; restorative justice; recreation; and social and spiritual activities. Residents have the opportunity to provide input into features of this program unit through the Resident Advisory Council that meets monthly or the community meetings which are held daily. A treatment plan of identified goals and objectives is developed for each resident based on his identified needs. The average length of stay is six to nine months.

Medical services for the campus are provided by the Health Services Administrator; eight Registered Nurses, and the physician who serves as the Designated Health Authority. Nurses are designated for each program unit. The physician visits the campus weekly and is on-call to the facility. The contract dentist is on-site weekly, and a contract optometrist visits the campus on an as needed basis. Mental health and case management services are provided on campus under the guidance of the Director of Treatment Services and Therapists and Case Managers are assigned to each program unit. A series of tests are administered that helps the education staff determine the appropriate grade level for each resident. An individualized education plan, including educational goals, is developed based on the results of the tests. Physical fitness and recreational activities are designed to offer the resident a chance to learn and practice new skills and increase overall physical wellness.

Victim awareness individual sessions and group meetings are conducted with the residents where they learn about the impact of their crimes on the community, how the crimes affected the victims, and victims' rights. Any court ordered sanctions will be identified at intake and are

incorporated in the resident's treatment plan. Staff members assist residents in completing court ordered sanctions which may include community service hours, apology letters or essays. Residents will not be able to pay restitution while in the facility; however, the Case Manager is available to assist the resident in planning for the payment prior to his discharge. The program contains a behavior management system known as the Behavior Motivation System consisting of three levels. It is designed to address immediate, short-term and long-term behavior and supports the development of the treatment plan. Incentives increase as the resident progresses through each level. The expectations of the resident are increased as he advances to each level of the Behavior Motivation System.

There are no known existing conflicts of interest with the Auditor and the facility and there were no barriers in completing any phase of the audit.

Audit Methodology

Pre-Onsite Audit Phase

In preparation for the on-site audit, a conference call was conducted with the Florida Department of Juvenile Justice (FDJJ) Statewide PREA Coordinator and the facility Superintendent, who also serves as the PREA Compliance Manager. During the conference call, an overview of the audit process was discussed and requested documentation was reviewed. There were also discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations prior to the site visit. The notifications of the on-site audit which provided Auditor contact information were posted six weeks prior to the audit. The postings of the notices were verified by photographs received electronically from the Superintendent. The photographs indicated notices were posted in various locations throughout the facility including the housing areas, educational areas, dining areas, and administrative areas. The audit notice was posted using color and large print that was easy to see and read. The notices were strategically placed throughout the facility, accessible to residents, staff, visitors, and volunteers. The posted audit notices contained the Auditor's contact information and included information regarding confidentiality. No correspondence was received during any phase of the audit. Further verification of their placement was made through observations during the site tour. The original notice was provided to the facility by the FDJJ PREA Coordinator and had previously been provided by CMCG to the FDJJ PREA Coordinator. The notice was posted in English at eye levels easy for a person to see either standing or sitting. All residents in the facility during the time of the site visit spoke and read English.

The Pre-Audit Questionnaire (PAQ), completed January 28, 2019, policies and supporting documentation were received within an adequate timeframe prior to the onsite visit for review. The documents were uploaded to a USB flash drive. The initial review revealed the flash drive was well-organized and easy to navigate. Any additional information needed was discussed with the Superintendent and was received within a timely manner or available for review during the onsite visit.

The PREA Coordinator had been previously provided a document by CMCG titled, "Information Requested to Determine Staff and Residents to be Interviewed During the On-Site PREA Audit." The document was forwarded to the Superintendent who completed and

returned the document to the Auditor. The document requested the identification of the staff members who served and performed in specific PREA related specialized roles within the facility, including volunteers and contractors who have contact with residents. The document requested a list of direct care staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation.

The Auditor communicated with the Superintendent to confirm schedules and to clarify specialized PREA roles. A current resident roster was also provided to the Auditor. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff and residents, including targeted resident interviews. The facility provided the lists and information before and during the site visit that assisted with the following determinations and interview selections:

Lists/Information	Comments
Complete Resident Roster	An up-to-date roster was provided prior to the site visit.
Youthful residents/detainees	Youthful residents/detainees identified on interview document sent to the facility.
Residents with disabilities	None were identified.
Residents who are Limited English Proficient	None were identified.
LGBTI Residents	None were identified.
Residents in segregated housing	None were identified.
Residents in Isolation	None were identified.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening.	None were identified
Staff roster for the time of the site visit.	The roster was provided during the pre-onsite phase of the audit.
Specialized Staff	Specialized staff was identified on interview document sent to the facility.
Contractors who have contact with the residents	Contractors were identified on interview document sent to the facility.
Volunteers who has contact with the residents	None were available for interview.
All grievances/allegations made in the 12 months preceding the audit	None
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	None
Hotline calls made during the 12 months preceding the audit	None
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	The facility reported there were no allegations of sexual abuse or sexual

	harassment in the 12 months preceding the audit.

The Auditor reviewed the lists/documents provided and conferred with the Superintendent in development of the interview schedule to ensure clarity regarding specialized PREA roles among staff.

Internet research of the facility revealed no indication of litigation, U. S. Department of Justice involvement, or federal consent decrees. General and specific information about the facility and the programs and services provided are detailed on the facility's website. An array of information, pictures of the facility and contact information may be accessed from the informative page. The facility's website also contains PREA information including but not limited to the zero-tolerance and coordinated response policies. The PREA audit report for the initial audit in March 2016 is located on the website and it also contains the third-party reporting form.

Onsite Audit Phase

During the pre-audit phase, the Auditor was provided a diagram of the physical plant which provided familiarity with the layout of the facility. The physical plant consists three buildings. Building 84 is designated for housing, medical, and therapy. Building 85 is designated for administration, dining hall, and school. Building 86 is not in use due to water damage. The grounds contain a recreation area with a gazebo and a basketball court and a much larger recreation area where various sports are played.

Upon arriving at the facility, an entrance meeting was held. Formal introductions were made and a review of the audit process, site visit activities and the itinerary were reviewed. Following the entrance meeting with the Superintendent and three Facility Administrators, a comprehensive tour of the facility was conducted, guided by the Facility Administrator. During the two-day onsite tour, youth were observed to be under constant supervision of the staff while involved in various activities. PREA signage was not displayed in all areas frequented by the residents; therefore, the Auditor recommended additional PREA signage be posted and ensure signage has bold print and is youth-friendly. Corrective actions were taken to rectify this issue. Photos of the additional signage were sent to the Auditor to verify the actions taken. The tour included all areas of the facility which included but was not limited to Intake, all housing units, medical, food services, industry areas, programming, and education areas. The facility was clean and well maintained. Staff, contractors and volunteers announced themselves prior to entering the housing area of the opposite gender.

Signage was observed on doors indicating youth are not allowed in the room/area or only allowed with staff supervision. Observation of bathrooms revealed shower stall openings have shower curtains to allow residents privacy when taking showers. However, there were no coverings to allow for privacy at the urinals. Corrective actions have been taken to address these concerns and photos of the empty walls, where the urinals were, have been sent to the Auditor to verify the actions taken. The shower procedures are printed and posted at the entrance of the bathroom in each housing unit. Observation of the surveillance system monitors revealed cameras do not capture showers, toilets or inside residents' rooms.

The signage posted includes instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services for the Treasure Coast Center (rape crisis center) in Okeechobee, FL. A Memorandum of Understanding (MOU) exists with the Treasure Coast Center to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The advocacy service was contacted and interviewed by phone and confirmed the advocacy services to be provided in accordance with the MOU.

Documentation and interviews with the Nurse and Facility Administrator confirmed forensic medical examinations will be performed at the Raulerson hospital. The hospital's Sexual Assault Policy provides that a Sexual Assault Nurse Examiner (SANE) will conduct the examinations. According to the Treasure Coast Center's written Policy, when a SANE is not available, the Emergency Department Physician and Emergency Department Nurse will assume care of the patient and follow the protocols outlined in the Policy.

Questions were answered by staff during informal interviews regarding resident activities and program services as the tour progressed throughout the facility. The site visit also included the outside grounds. During the tour, the intake process was described, and the daily scheduled activities and staff supervision were discussed by the Facility Administrator. There were no new admissions during the site visit. Staff readily explained activities as different facility areas were visited.

Staff of the opposite gender, must announce their presence when entering the housing unit or any area where a resident shower, change clothes, or perform bodily functions. All residents interviewed stated the staff members announce their presence prior to entering the housing unit. This practice was experienced and observed during the tour.

Medical Request Forms, PREA/grievance forms, and the locked boxes for each are posted in the common area, accessible to all residents, staff and visitors. All residents have access to writing utensils needed for completing the forms. The doors to closets and storage rooms are kept locked.

Interviews

Thirty-five staff members are currently employed at the facility that may have contact with residents. During the on-site visit, 12 random direct care staff from the two shifts and nine specialized staff were interviewed. The interviews revealed staff are knowledgeable of PREA standards and were able to articulate their responsibilities in the PREA roles. The Superintendent/PREA Compliance Manager was interviewed; however, he was not counted as specialized staff. Although nine individuals were identified for specialized interviews, the specialized interviews conducted totaled eight due to staff members in this category serving in more than one PREA related specialized role. Ten residents were also interviewed after randomly selecting the names from the facility population report, considering each housing unit and information regarding the make-up of the population. The interviews revealed the residents were informed of their right to be free from sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. Most residents indicated that they

learned of PREA during their stay at the Juvenile Assessment Center (JAC). The resident population on the first day of the onsite audit was 30. A previous inquiry was made regarding vulnerable categories within the resident population related to the selection of targeted interviews. There were no targeted residents interviewed at this facility during this auditing cycle.

The training records of staff interviewed, and the files of residents interviewed were reviewed along with policies and other secondary documentation. The Auditor reviewed staff, contractor and volunteer training records to ensure that all required training had been completed. The Auditor also reviewed staff personnel files related to completed investigations and disciplinary actions taken regarding PREA related allegations. There were no allegations of sexual abuse and/or sexual harassment within the facility in the past 12 months.

The Auditor conducted 10 resident interviews in the following categories during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	10
Targeted Resident	0

The Auditor conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews
Facility Administrator	1
PREA Compliance Manager	1
Medical Staff	1
Mental Health Staff	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
Education/Program Staff	1
Volunteer/Contractor who have Contact with Residents	1
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Non-Security Staff First Responders	All Staff are 1st responders (1)
Intake Staff	1

Number of Specialized Staff Interviews	13
Number of Random Staff Interviews	12
Total Random and Specialized Interviews	25
Total Interviews plus Superintendent/PREA Compliance Manager	26

Onsite Documentation Review
The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the Pre-Onsite Audit Phase and the Onsite Audit Phase the auditor reviewed a sample of personnel files of the staff selected to be interviewed, including documentation of criminal background checks occurring. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed. The secondary documentation reviewed included but was not limited to Vulnerability Assessments; PREA/Grievance Form; Medical Request Form; PREA education and training acknowledgement forms; training records; checklists; sexual abuse coordinated response plan; annual staffing plan assessment; staffing plan; staff schedules; unannounced rounds reports; retaliation monitoring form; organization chart; and other documentation. The facility reports there were no allegations of sexual abuse or sexual harassment in the past 12 months.

Additional information for the audit process was provided upon request and in a timely manner while on-site. A close-out meeting was held at the conclusion of the on-site audit with the Superintendent and Facility Administrator to allow the opportunity for questions and to review the on-site audit process was provided. The timelines for the submission of PREA reports were reviewed.

Post Onsite Audit Phase
The Auditor contacted the Facility Administrator regarding clarity of information. The final report was concluded on the posted date. The Auditor determined the information and documentation received and reviewed and the results of the site visit confirmed all the standards were met as indicated below and detailed throughout this report. The report was submitted to the FDJJ PREA Coordinator to be reviewed and subsequently forwarded to the facility.

With the necessary corrective actions addressed, the facility was found to be in compliance with all applicable standards.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The OIHH is a 30-bed residential facility for male juvenile residents ages 13-18 years of age who have been committed to the Florida Department of Juvenile Justice (FDJJ). Twenty-four

residents have been admitted to the OIHH facility in the past 12 months. The number of residents admitted to the facility during the past 12 months whose length of stay was more than 10 days is 24. The number of staff employed at the facility in the past 12 months who may have contact with residents is 35. In the past 12 months there have been three contracts for services with contractors who might have contact with residents and there are three volunteers who may have contact with residents. There were 30 residents in the facility during the on-site visit.

The OIHH is located on a large campus with two other distinct program units. This unit consists of two primary buildings, administration and housing. The administration building contains three classrooms, including a computer lab; dining hall; offices; and conference room. The meals are delivered from the central kitchen and the dining room is also used for groups and other social activities. The housing building contains offices for two Case Managers, two Therapists and the shift supervisor. There are three dorms and each one has 10 beds and a TV room. The bathroom with showers and toilets is adjacent to the living area. Residents are provided with a reasonable amount of privacy during showers, when they are changing clothes, and when using the toilet. Signs are posted on the doors where residents are not allowed to enter or where they may enter, accompanied by staff.

The outside grounds immediately surrounding the unit contain a gazebo near the administration building that may be used for counseling sessions, cooling-off, and meditation. There is also an area that is used for basketball, football and other games and recreational activities. Family Day activities may also be held in this area. A covered gazebo is located between the housing and administration buildings and is used for group therapy, cookouts and games. There is a large gymnasium on the grounds for the use of all three program units through coordinated schedules.

The facility provides supervision of youth in a safe, secure and humane environment. The facility operates with a total of 35 full-time employees including a Facility Administrator, an administrative staff, supervisors, a unit manager, maintenance staff, food support staff, mental health staff, medical staff, educational staff, transition service manager, and line-staff. Services for youth include education, mental health, substance abuse and medical health care. Medical services are contracted with Camelot Health Care Services and Mental Health services are contracted with Maxim Health Care Services. Medical and Mental Health Services are available to youth seven days a week. The contracted staff consists of Food Support, a Physician, an Advanced Registered Nurse Practitioner, Registered Nurses and Licensed Practical Nurses as well as a Licensed Mental Health Counselor. The educational services are funded by the Florida Department of Education through the Washington County Public Schools.

Direct care staff members/random staff are responsible for the daily and direct supervision of residents and manage them during their daily activities. The staff to resident ratio was observed to be met in all areas of the facility during the on-site tour. The camera monitoring system, in addition to mirrors, support the direct supervision provided by staff. The cameras were observed to be constantly monitored.

There is a host of management, supervisory, support and contract staff members who provide oversite of or participation in processes and activities that contribute to the facility operations. Allegations that are criminal in nature are investigated by the Okeechobee Sheriff's Office as confirmed through interviews.

The resident interviews, documentation and observations confirmed the provision of the programs and services described. The residents indicated they could communicate with their parents/guardians through telephone calls and visits. Observations during the tour revealed adequate space for conducting the programs and services described. There is enough space to accommodate visitation and meetings in private, as needed.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: 0

Click or tap here to enter text.

Number of Standards Met: 41

Click or tap here to enter text.

Number of Standards Not Met: 0

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Summary of Corrective Action (if any)
Specific corrective actions taken to address the deficiencies identified during the review and on-site visit are summarized in this report under the related standard.

Standard 115.315 Limits to cross-gender viewing and searches
Standard 115.333 Resident Education

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
PREA Pre-Audit Questionnaire
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Organizational Chart
PREA Coordinator's Job Description

2017 Annual Report

Interviews:
PREA Coordinator
Random Staff
Residents

Provision (a):
An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The FDJJ PREA Policy 1919 and OIHH Facility Operating Procedure (FOP)-PREA, mandates zero-tolerance of sexual abuse and sexual harassment and outlines how the facility carries out its approach to preventing, detecting and responding to sexual abuse and sexual harassment. The Policy and FOP includes definitions of prohibited behaviors and sanctions for those found to have participated in prohibited behaviors. The Policy and FOP also provides strategies and responses for reducing and preventing sexual abuse and harassment.

Provision (b):
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

OIHH is a juvenile residential facility governed and operated by the Florida Department of Juvenile Justice (FDJJ) which employs an agency-wide PREA Coordinator who is in an upper-level management position within the agency. An interview with the PREA Coordinator revealed he has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of the agency's facilities.

Provision (c):
Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

The Superintendent also serves as the PREA Compliance Manager. An interview with the PREA Compliance Manager revealed he has sufficient time to oversee the facility's PREA compliance efforts and to perform his other duties.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
PREA Pre-Audit Questionnaire
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA

Interview:
Superintendent

Provision (a):
A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

Currently, FDJJ has 82 contracts with providers for the confinement of juveniles in residential facilities throughout the State of Florida. A review of a signed contract revealed provider's agreement to comply with all requirements and standards of the Prison Rape Elimination Act 28 CFR Part 115 as outlined in FDJJ Policy 1919.

Provision (b):
Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

All contracts require FDJJ to monitor the contractor's compliance with PREA standards.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility contracts for the confinement of its residents.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any

judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours,

except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☐ Yes ☒ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

- 115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Staffing Plan
Staffing Plan Assessment
Monthly Schedule
Resident Daily Rosters
PREA Pre-Audit Questionnaire

Interviews:
Facility Administrator
PREA Compliance Manager

Provision (a):
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

FDJJ Policy 1919 and OIHH FOP-PREA requires the facility to develop, implement and document an approved staffing plan. Facility Administrator interview verified the development of the facility's staffing plan, the continual assessment of adequate staffing levels and the need for video monitoring.

Provision (b):
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances.

The staffing plan is based upon the facility's capacity of 30 residents. OIHH FOP- PREA requires the facility to document deviations from the staffing plan on the Shift Report however due to the facility's hold-over policy, there were no deviations from the plan to review.

Provision (c):
Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

The Facility Administrator's interview confirmed there is no law, regulation or judicial decree to maintain staffing ratios of 1:8 staff to resident ratio during waking hours or a 1:16 staff to resident ratio during sleeping hours; however, the facility's staffing plan does reflect the required ratios. Observation during the tour revealed the staff to residents' ratio exceeds requirements.

Provision (d):
Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.
Documentation of the annual assessment of the staffing plan dated May 8, 2018 was reviewed and found to be in compliance with all elements contained in (d)-1 of this standard.

OIHH utilizes video monitoring combined with direct staff supervision to protect residents from sexual abuse and sexual harassment. FDJJ Policy 1919 and OIHH FOP PREA requires intermediate or higher-level staff to conduct unannounced rounds to deter and identify staff sexual abuse and sexual harassment.

Provision (e):
Each secure facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such

announcement is related to the legitimate operational functions of the facility.

An interview with a higher- level staff member and a review of unannounced rounds documentation revealed over time unannounced rounds are conducted on both shifts in all areas of the facility.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding supervision and monitoring.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? X Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
PREA Pre-Audit Questionnaire
Training Curriculum
Training Acknowledgement Statements
Training Sign-in Sheet
Posted Signs

Interviews
Random Staff
Residents

Provision (a):
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

FDJJ Policy 1919 and OIHH FOP PREA prohibit cross-gender strip searches, or pat down searches of youth, except in exigent circumstances and there have been no such searches conducted by direct care staff in the past 12 months as verified by random staff and random resident interviews.

Provision (b):
The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

OIHH FOP Searches states body cavity searches require the Facility Administrator's authorization and must be conducted by licensed medical personnel in a medical establishment. There were no body cavity searches of residents in the past 12 months.

Provision (c):
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches may be conducted only in exigent circumstances which random staff interviews summarized as an extreme emergency. The Policy indicates that in the event a cross-gender search is warranted pursuant to an emergency circumstance, it must be approved by the Facility Administrator and the justification for the search documented. Such searches will be documented on a form currently used for all searches which have been used for same sex searches. The form requires the staff to record the reason for the search. The evidence shows the facility is prepared to document and justify all cross-gender pat-down searches. Based on the review of the Pre-audit questionnaire and the Resident Pat Down Searches & Control of Contraband Accountability Form, staff and resident interviews, and staff training materials, the facility follows this provision of the standard.

Provision (d):
The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely

to be showering, performing bodily functions, or changing clothing.

FDJJ Policy 1919 PREA and OIHH FOP PREA require opposite sex staff, volunteers and contractors entering housing units to announce themselves. Resident interviews verified this is done on consistent bases.

OIHH FOP PREA states the facility must be configured to allow residents to shower, perform bodily functions and change clothing without staff of the opposite sex viewing their bodies. Staff and resident interviews confirm there is no cross-gender viewing. Observation of the bathrooms revealed all shower stalls have shower curtains to allow privacy while taking showers. Staff members of the opposite gender are required to announce themselves upon entering the unit. This practice was confirmed through observation of signage indicating such, observations and interviews with residents and staff. No residents interviewed reported ever having been naked in full view of female staff while showering, changing clothing, and performing bodily functions. The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia. Based on the review of the documentation, staff and resident interviews, and observations, the facility follows this provision of the standard. Additionally, viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes. However, there were no coverings to allow for privacy at the urinals. Corrective actions have been taken to address these concerns and photos of the empty walls, where the urinals were, have been sent to the Auditor to verify the actions taken. The shower procedures are printed and posted at the entrance of the bathroom on each unit. Observation of the surveillance system monitors revealed cameras do not capture showers, toilets or inside residents' rooms.

Provision (e):
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

FDJJ Policy 1919 and OIHH FOP PREA prohibit the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. According to the Policy, if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. One hundred percent of direct care staff received the training on conducting cross-gender pat-down searches and searches of transgender and intersex residents. Staff interviews confirmed they are aware facility policy prohibits them from conducting a physical examination of transgender or intersex resident solely for the purpose of determining the resident's genital status. Based on the documentation reviewed and staff interviews, the facility meets this provision of the standard.

Provision (f):

The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

FDJJ Policy 1919 and OIHH FOP PREA states that staff shall be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews support the training is conducted at least annually. Training participation is documented with sign-in sheets and training acknowledgement forms. The evidence shows staff are trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:
One hundred percent of direct care staff have received training on cross-gender pat down searches and searches of transgender and intersex residents as verified during interviews of random staff. The interviews revealed staff are knowledgeable of PREA standards and were able to articulate their responsibilities in the PREA roles. Training curriculum and training logs were reviewed and confirmed compliance. Based on the reviewed documentation and interviews, the facility follows this provision of the standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (If "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Memorandum of Understanding (MOU), The School Board of Okeechobee County, FL
Language Line Services, Inc. Purchase Order
List of Bilingual Staff able to translate
FDJJ Special Needs Directives and Alerts

Interviews:
Facility Administrator
Residents
Random Staff

Provision (a):
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

The Policy and FOP addresses the provision of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Policy and FOP prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, performance of first responder duties, or the investigation of the allegations. Staff interviews confirmed this information. The facility has a MOU with the School Board of Okeechobee County for supportive services to residents with disabilities or who may be limited English proficient which was verified through the interview with the Facility Administrator.

Provision (b):
The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

An Interpreting and Translation Agreement is documented with Language Line Services, Inc. for services to residents. The evidence shows residents with disabilities and who may be limited English proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. All staff interviewed confirmed residents are not used as interpreters and understand prior arrangements have been made regarding language interpreters. There are staff who can speak and translate in other languages in an emergency situation. The evidence shows the facility ensures access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary.

Provision (c):
The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

According to Policy and FOP, the facility prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents have not been used to relate PREA information to or from other residents in the past 12 months. There were no residents in need of an interpreter during the site visit.

FDJJ's South Region has a blanket purchase order with Language Line Solutions, Inc. to provide interpreter services for facilities in the South Region. A letter from Okeechobee County School District confirms their ability to provide services for hearing-impaired, visually

impaired and other residents on a as needed bases to provide them with an equal opportunity to participate in or benefit from all aspects of the agency's effort to prevent, detect and respond to sexual abuse and sexual harassment. Mental Health professionals are also trained to provide appropriate explanations regarding PREA to residents, when needed.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited English Proficient. Residents with disabilities and who are limited English Proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☐ Yes ☒ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of

materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Personnel Files

Interviews:
Administrative (Human Resources) Staff

Provision (a) & (f):
(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described

in paragraph (a)(2) of this section.
(f) The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

FDJJ Policy 1800 Background Screening, FDJJ Policy 1919 PREA and OIHH FOP Hiring and Promotions address hiring and promotion processes and decisions, including the requirement for background checks for new hires. The collective policies and interview with the Human Resource staff member revealed information regarding the hiring process, completion of background checks, and the grounds for termination. The policies are aligned with the requirements of the standard and provide that background checks are conducted every five years. A review of a sample of personnel files confirmed compliance.

The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while on site. Additional personnel information reviewed during the pre-audit and the onsite audit phases included: Offender Watch Registry checks; Pre-Hire Interview Questions; New Hire Application Packet; Applications; results of Diana Screens. The interview with the Facility Administrator and a review of Policy and FOP provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. According to the interview, staff has a continuing duty to report related misconduct and omission of sexual misconduct or providing false information will be grounds for termination. The forms completed and included in the personnel files are in response to the above provisions of this standard.

According to FOP, all applicants are asked about any prior misconduct involving any sexual activity. In addition, OIHH shall not hire or promote anyone who has been civilly or administratively adjudicated to have been convicted of engaging in or attempted to engage in sexual activity by any means. Also, OIHH does not hire anyone who has engaged in sexual abuse in a prison, jail, community confinement facility, or anyone, who has used or attempted to use force in the community to engage in sexual abuse.

Provision (b):
The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

According to the Human Resource staff, the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee. Policies FDJJ 1800 and FDJJ 1919 and an interview with the Human Resource staff provide that staff has a continuing duty to report misconduct and provide that omissions of misconduct or providing false information will be grounds for termination.

The Policy and FOP states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. The interview with the HR Staff was aligned with the standard. The interview questions for employment also address previous misconduct. The evidence shows the facility considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview with the Facility Administrator, the facility follows this provision of the standard.

Provisions (c) & (d):
(c) Before hiring new employees or (d) contractors who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

The policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the Facility Administrator's interview. Additionally, best efforts should be made to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Based on the review of documentation and interview with the Facility Administrator, the facility follows this provision of the standard.

The Facility Administrator provided documentation that Florida State law does not allow FDJJ or other agencies to contact the abuse registry for the purpose of screening applicants.

Provision (e):
The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

The Policy and FOP is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while onsite and during the pre-audit phase. This was also confirmed during the Facility Administrator's interview. Based on the review of documentation and the interview, the evidence shows the facility practices are aligned with the provisions of this standard.

A review of personnel files for a sample of staff hired in the past 12 months revealed that all had criminal records checks and a sample review of personnel files of current staff employed for more than 5 years revealed that all have had criminal background checks conducted every five years.

Provision (g):
Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

FOP states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Based on the review of the documentation and the interview with the Facility Administrator, the evidence shows the facility follows this provision of the standard.

Provision (h):
Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The interview with the Facility Administrator confirmed the facility would provide this information if requested to do so. Policy and FOP states the information would be provided when requested unless it is prohibited by law to provide the information.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

OIHH FOP PREA requires when installing or updating a video monitoring system, electronic surveillance system or other monitoring technology, the facility will consider how such technology may enhance the ability to protect residents from sexual abuse.

Documentation of the annual staffing plan assessment referenced 12 operating cameras in the facility. No blind spots were identified at that time.

During the facility tour, the video surveillance system was observed, and all cameras were pointed out by staff.

The interview with the Facility Administrator and according to the Pre-Audit Questionnaire, OIHH has not acquired any new facilities since August 20, 2012. The video monitoring system was assessed during the annual review of the staffing plan. Policy and FOP states that when there is substantial expansion to the facility, the ability to protect residents and staff from sexual abuse will be reviewed and ensured.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
  ☐ Yes ☐ No ☒ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No
- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Inspector General Directive
FDJJ Evidence Protocol
Memorandum of Understanding (MOU), Treasure Coast Center
Staff Training Certificate
Resident Brochure

Interviews:
Direct Care Staff
Facility Administrator

PREA Compliance Manager

Provisions (a) & (b):
(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.
(b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

Policy and FOP provides for the uniform FDJJ Protocols to be followed. The Protocol is outlined regarding appropriateness for youth and adults. The FDJJ Protocol, developed by related professionals, addresses but is not limited to interviewing; evidence collection; victim services; notifications; and prosecution of sexual assault cases. The agency-based investigators conduct administrative investigations and the Okeechobee Sheriff's Office investigate sexual abuse allegations that are criminal in nature. The Sheriff's Office agrees to follow the FDJJ Protocol. Staff interviews confirmed an understanding of the facility's protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

Provision (c):
The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policy states forensic medical examinations will be conducted at the Raulerson Hospital who employs Sexual Assault Nurse Examiners (SANE) and Sexual Assault Forensic Examiners. The Sexual Assault Policy of the hospital states that the medical forensic examination will be conducted by a SANE or SAFE. The facility Policy states that the services will be provided at no cost to the victim. The Nurse's interview was aligned with the facility Policy.

Provisions (d) & (e):
(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The

agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The facility has a MOU with the Treasure Coast Center for victim advocacy services. According to the MOU, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The Facility Administrator confirmed that advocacy services will be provided in accordance with the MOU. The interview with the Facility Administrator confirmed the resident and/or facility staff members are able to utilize the victim service hotline to request a victim advocate.

Provisions (f), (g) & (h):
(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section.
(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.
(h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

OIHH FOP PREA requires staff to report allegations of sexual abuse to the Okeechobee Sheriff's Office for criminal investigations and to the Florida Central Abuse Hotline and FDJJ's Central Communication Center (CCC). OIHH does not have a Memorandum of Understanding (MOU) however the policy states when the Okeechobee Sheriff's Office arrives at the facility to conduct an investigation, facility staff will provide and request the investigative agency to follow the DJJ Inspector General Directive 3-05 (uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for criminal prosecution and appropriate for youth).

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
PREA Pre-Audit Questionnaire

Interviews:
Random Staff
Facility Administrator
PREA Coordinator

Provision (a):
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports. Staff members are aware of the Policy requirements as verified through their interviews. The facility reports one allegation of sexual abuse and sexual harassment. The facility Policy ensures the cooperation between the facility staff and the Okeechobee Sheriff's Office.

Provision (b) and (c):
The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. Provision (c): If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

The facility's website provides the information and related policies for reporting allegations of sexual abuse. A third-party reporting form is also on the website. Reporting information is also posted in various areas of the facility including but not limited to living units. The posted information is accessible to residents, staff, contractors and visitors. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the trained facility investigators and sexual abuse allegations that are criminal in nature are investigated by the Okeechobee Sheriff's Office.

Provision (d):
Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

OIHH PREA FOP requires the immediate referral of all sexual abuse allegations to the Okeechobee Sheriff's Office, the Florida Abuse Hotline and FDJJ's CCC. Interviews with the Facility Administrator and random direct care staff verified their knowledge of the policy's requirements. The facility and the Okeechobee Sheriff's Office have policies governing investigations.

Provision (e):
Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

A review of FDJJ's website revealed a PREA page includes investigative entities responsibilities for conducting investigations of allegations of sexual abuse.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No?
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of

sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:

Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Staff SkillPro PREA Curriculum
Training Attendance Record (Sign-in Sheets)
PREA Training Acknowledgement Statements

Interviews:

Random Staff
Facility Administrator
PREA Compliance Manager

Provisions (a) and (c):

(a)The agency shall train all employees who may have contact with residents on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;

(11) Relevant laws regarding the applicable age of consent.

(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The agency Policy and FOP addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented.

The direct care staff interviewed and the PREA Compliance Manager reported the training is provided as required. All direct care staff members interviewed, and document review verified the general topics below were included in the training:
1. Zero-tolerance PREA related policies.
2. Staff responsibilities and how to fulfill them regarding allegations or incidents of sexual abuse or sexual harassment.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation.
5. Dynamics of sexual abuse and sexual harassment in juvenile facilities.
6. Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment.
7. How to avoid inappropriate relationships with residents.
8. Common reactions of sexual abuse and sexual harassment by juvenile victims.
9. Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents.
10. Mandatory reporting.
11. Relevant laws regarding the applicable age of consent.

The Policy and FOP, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs. Training is conducted annually, and refresher training is provided as needed. Staff interviews confirmed they have received training on the 11 required topics. The interviews revealed staff are knowledgeable of PREA standards and were able to articulate their responsibilities in the PREA roles.

Provision (b):
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses male only and the training considers the needs of the population as determined by a review of training curricula and interviews with random staff. The Policy state the training shall be tailored to the needs and attributes to the population served.

Provision (d):
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy and FOP provides all training be documented. Staff members sign training rosters and training acknowledgement statements. A checklist is utilized for orientation training for all new employees and contains the elements of PREA training. The facility provided the Auditor with several examples for verification of the training occurring and the training was verified through staff interviews. The facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Volunteer and Contractor Training Curriculum
PREA Notification/Acknowledgement Statement

Interviews:
Education Staff
Facility Administrator

Provision (a):
The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The Policy and FOP require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records and interviews document the training occurs.

Provision (b):
The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers. The education staff member stated the training includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Provision (c):
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The PREA Notification document contains the information reviewed with the contractor and volunteer. The document also serves as the training acknowledgement statement containing the signature of the participant and the date, confirming their understanding of the PREA information.

The review of training records revealed volunteers and contract providers are given a downloaded version of the SkillPro on-line PREA training, asked to read it and given the opportunity to ask questions prior to signing acknowledging they understand the contents of the documents regarding PREA.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by

information on specific corrective actions taken by the facility.

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
PREA Safety Brochure
Acknowledgement Statements
PREA Posters

Interviews:
Residents
Intake Staff

Provisions (a) and (b):
During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Provision (b): Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

FDJJ Policy 1919 PREA and OIHH FOP PREA provides all residents admitted receive information about the facility, including PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. According to the Intake staff who provides PREA education to residents and the residents interviewed, an orientation is provided to residents during the intake process. Policy provides that residents receive a comprehensive age-appropriate PREA education session within 10 days of admission to the facility. The results of the staff and resident interviews indicated the information provided to the residents is comprehensive and age-appropriate.

The intake staff's interview revealed she ensures residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. The PREA education sessions include a review of the Safety Brochure. The residents sign acknowledgement statements confirming their receipt of the PREA information. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA related information is provided to staff in policies and procedures, training and staff meetings.

Provision (c):
Current residents who have not received such education shall be educated within one year of

the effective date of the PREA standards and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Provision (d):
The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Documentation was reviewed of a MOU between the facility and Okeechobee County Board of Education for the provision of accommodations and supportive services for residents in the aforementioned areas. Posted PREA information is in English and Spanish accessible to residents, staff, contractors, volunteers, and visitors. The facility also has a MOU with Language Line Solutions for interpreting and translating services. Staff interviews confirmed residents are not used as translators or readers for other residents.

Provision (e):
The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. The Intake staff was interviewed regarding PREA education for residents. She ensures residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (f):
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; or complete a PREA/grievance form. Each resident is provided a Safety Brochure. The Auditor observed the lack of PREA information in all areas frequented by the residents. As a corrective action, the Facility Administrator has displayed additional and youth friendly postings of PREA information in all areas frequented by the

residents. Photographs have been provided to this Auditor to verify the actions taken.

Staff present the PREA information in a manner that is accessible to all residents. If needed, the facility has internal and external resources to provide translation services through staff or Language Line Solutions, Inc. for residents who may be limited English proficient or through Okeechobee County Schools for hearing and visual impairment services and for residents with other disabilities.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]

☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Inspector General Directive
Training Curriculum
PREA Compliance Form

Interviews:
Facility Administrator

Provision (a) & (b):
In addition to the general training provided to all employees pursuant to §115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Provision (b): Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

FDJJ Policy 1919 PREA and OIHH FOP PREA provides for investigations of allegations of sexual abuse that are criminal in nature to be conducted by the Okeechobee Sheriff's Office. The Policy and FOP provides for the investigators to be trained.

Provision (c):
The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

FDJJ Policy 1919 PREA states local law enforcement agencies and the Florida Department of Children and Families Services conduct criminal investigations into allegations of sexual abuse. FDJJ's Office of Inspector General (OIG) conducts administrative and management reviews, separate and apart from any criminal investigation. The policy further states the OIG staff will be trained on the policies and procedures for the Department policies and procedures related to handling of sexual misconduct incidents and reports.

Provision (d):
Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

Facility staff does not conduct administrative nor criminal investigations into allegations of sexual abuse and sexual harassment.

Conclusion:
Based upon the review and analysis of the available evidence, the auditor has determined the facility is compliant with this standard regarding specialized training for investigations.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Contractor Training example
PREA-Mental Health and Medical Professional Training example
Power Point Training Modules

Interviews:
Nurse
Counselor

Provision (a):

The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

FDJJ Policy 1919 PREA and OIHH FOP PREA provide medical and mental health staff members receive the regular PREA training as well as the specialized training. Training records document specialized training for medical and mental health staff members. Specialized medical and mental health training is provided through SkillPro, FDJJ's online E-Learning system. Documentation of specialized training was reviewed for all medical and mental health staff and confirmed during interviews of medical and mental health staff. The interviews with the Nurse and Counselor and a review of training certificates, curricula, and training logs confirmed completion of training which includes the provisions of the standard.

Provision (b):
If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

Forensic examinations are not conducted by the facility's medical staff as verified during the medical staff interview. Forensic examinations are conducted at the Raulerson Hospital by SANE or SAFE certified examiners.

Provision (c):
The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

The training documents, including training certificates and the interviews with medical and mental health staff confirmed receipt of the required training.

Provision (d):
Medical and mental health care practitioners shall also receive the training mandated for employees under Standard 115.331 or for contractors and volunteers under Standard 115.332, depending upon the practitioner's status at the agency.

Medical and mental health staff completed the general training that is provided for all staff members as documented by training documentation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding specialized training for medical and mental health care.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:

Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Sample of Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression

Interviews:
Facility Administrator
PREA Compliance Manager
Staff Responsible for Risk Screening
Residents

Provision (a):
Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The Policy provides a risk screening occurs within 72 hours upon arrival to the facility. The Intake Coordinator will interview the resident at intake to obtain information about the resident's personal history and behavior in order to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed periodically.

OIHH FOP PREA requires staff to complete the FDJJ's Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) form if youth arrive from the Juvenile Assessment Center (JAC) without a completed form or is returning from a residential program. JAC staff and Intake staff obtain information from court records, current charges, and interviews with the resident and his/her parents. The Intake staff interview confirmed compliance with this standard.

Resident interviews indicated they were asked whether they identify with being gay, bi- sexual, transgender or intersex, if they think they are in danger of sexual abuse and if they have any disabilities. Random resident interviews verified they were asked the same questions by mental health staff during their initial interview.

Disclosure of prior victimization or perpetrated sexual abuse is addressed during the time of disclosure. The information is related to mental health personnel following the disclosure of the information. There was no resident in the facility who had disclosed prior victimization. A review of documentation, interviews with residents and staff confirmed the Vulnerability Assessment is administered. The information for the instrument may be obtained by asking questions from the form, medical and mental health screenings and other methods. All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment. Reassessments are conducted periodically. PREA Education and Screening log was reviewed and it is maintained indicating the administration of the initial assessment and the completion of the follow-up assessments.

The facility provided the Auditor with examples of the screening tool. The Intake staff, responsible for risk screening, confirmed residents are screened whether a new admission or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward the other residents. The risk screening occurs within 72 hours of intake, usually on the

first day. Risk levels are reassessed periodically per the Intake Coordinator and a review of documents. All residents interviewed entered the facility within the past 12 months. They confirmed they were asked questions like the following examples at intake:
(1) Have you have ever been sexually abused?
(2) Do you identify with being gay, bisexual or transgender?
(3) Do you have any disabilities?
(4) Do you think you might be in danger of sexual abuse at the facility?

Based on the review of the Pre-audit questionnaire, review of resident records, interview with the staff responsible for risk screening, and resident interviews, the evidence shows that resident's risk levels are assessed during intake, but no later than 72 hours of their arrival at the facility. Additionally, risk levels are reassessed periodically. The facility follows this provision of the standard.

Provision (b):
Such assessments shall be conducted using an objective screening instrument.

The Vulnerability Assessment is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of Policy and FOP revealed how the objective instrument is administered to obtain information to assist staff in keeping residents safe. The responses on the instrument accumulate a score and the risk level is determined by definition and the corresponding number to that definition. The Policy and FOP states residents will be screened within 72 hours of admission however interviews with residents indicated it is also administered earlier.

Provision (c):
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression screening instrument and determined all factors required by this provision of the standard are included. The interview with the Intake staff confirmed he is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument.

Provision (d):
This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The FDJJ Policy 1919 PREA and OIHH FOP PREA states the information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file. The staff and resident interviews are aligned with the Policy and FOP and this provision of the standard. The review of the instrument and interview with the Intake staff responsible for risk screening confirmed the information is ascertained through conversations with the residents using the Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression screening instrument. Resident interviews also revealed the instrument is used. Additional screening instruments are used and based on the needs of the resident.

Provision (e):
The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.
The Policy and FOP provides for appropriate controls be taken to ensure that sensitive information is protected and not exploited. The interview with the PREA Compliance Manager revealed the completed VSAB forms are maintained in residents' medical and Intake files and are available to staff only on a need to know bases. The Auditor observed the files to be maintained in a secure manner. The evidence shows the facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding screening for risk of victimization and abusiveness.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently,

with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any

  legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Sample of Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression (VSAB)
FOP Admissions
FOP Classification
FOP Alerts
VSAB Curriculum

Interviews:
Facility Administrator
PREA Compliance Manager
Staff Responsible for Risk Screening/Intake Staff
Residents
Random Staff

Provision (a):
The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

OIHH FOP PREA requires victimization screening information to be used to determine a resident's room assignment and room's proximity to direct care staff to ensure resident's safety. The PREA Compliance Manager interview confirmed the facility's compliance with this

standard. The facility also utilizes the Classification Alerts to ensure that direct-care staff are advised if the resident is identified as being at-risk for victimization or posing a risk.

The facility Policy provides guidance to staff regarding the use of the information obtained from the Vulnerability Assessment: Risk for Victimization and/or Sexual Aggressiveness. The staff interviews and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified through a review of specific samples of the aforementioned completed screening instrument. The facility also uses additional screening instruments.

Provision (b):
Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Policy states any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall comply with § 115.342 and the provision (a). At no time will any client be denied any legally required educational programs, special education services, daily large-muscle exercise, or medical/mental health care. At risk residents may only be placed in isolation in an emergency situation, and only as a last resort if less restrictive measures are inadequate to keep the resident safe.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. The interview with the Facility Administrator confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation. The use of isolation would be documented. The residents' rights to daily large-muscle exercise and any legally required educational programming or special education services would be provided. Based on the review of the Pre-audit questionnaire, related documents and interview with the Facility Administrator, the evidence shows the facility follows this provision of the standard.

Provision (c):
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

OIHH FOP PREA precludes lesbian, gay, bi-sexual, transgender and intersex residents from being placed in a particular module and states LGBTI identification or status is not an indicator of likelihood of being sexually abusive. Transgender or intersex resident's own view with respect to his/her safety will be given serious consideration. The PREA Compliance

Manager's interview also verified compliance with this standard.

During the site tour, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for a reasonable amount of privacy. A staff interview and observations revealed there is no special housing based on how a resident identifies.

Provision (d):
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The Policy and FOP also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were no transgender or intersex residents in the facility during the site visit and this audit period. The Intake staff's interview confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Provision (e):
Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The Policy and FOP states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. This function would be done to review any threats to safety experienced by the resident and the Intake staff is aware of the requirement. The Intake staff confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident. Based on the review of the Pre-audit Questionnaire and interview with the Intake staff, the evidence shows the facility follows this provision of the standard.

Provision (f):
A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

The resident's concern for his own safety is taken into account through the administration of the Vulnerability Assessment and this applies to every resident. The residents confirmed in the interviews, they are asked about their safety concerns. A review of the PREA Education & Screening Log demonstrated the additional documentation of the screening assessments and re-assessments completed for each resident. The staff interviews revealed staff members are aware of the Policy which requires the provision of the standard to be followed.

Provision (g):
Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Transgender and intersex residents are given the opportunity to shower separately from other youth. The policy also states isolation or room restriction may be used as a last resort when less restrictive measures are inadequate to ensure youths safety and only until an alternative means of keeping all youth safe can be arranged.

Provision (h):
If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.

The Policy states if a resident is isolated pursuant to part (B.2.) of this section, the facility shall document:
a. The basis for the facility's concern for the resident's safety; and
b. The reason why no alternative means of separation can be arranged.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Facility Administrator/PREA Compliance Manager confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation. The Isolation/separation would be documented according to the provisions of the Policy and standard.

Provision (i):
Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

The Policy states every thirty (30) days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Facility Administrator/PREA Compliance Manager confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding use of screening information. The facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The facility prohibits placing LGBTI residents in particular housing, bed, or other assignments solely on the basis of such identification or status and does not consider such identification or status as an indicator of likelihood of being sexually abusive.

The facility is prepared to provide a safe and secure environment and follow all provisions of this standard.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual

harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
PREA/Grievance Forms
Medical Request Form
Third Party Reporting Forms
Safety Brochure
Sample of Incident Report
Resident Reporting Poster
Multilingual Posters
MOU, Victim Services SART Center

Interviews:
Random Staff
Residents
Facility Administrator
PREA Compliance Manager

Provision (a):
The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

OIHH FOP PREA provides multiple internal ways for residents to privately report sexual abuse

and sexual harassment, retaliation and staff neglect including telling a trusted staff member or filling out a PREA Reporting form and placing it in a secure drop box. Random resident interviews confirmed their knowledge of this procedure. FOP addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, including how he/she can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such.

Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour hotline of an agency not a part of the facility as confirmed by resident interviews, posters, staff, MOU, and posted phone instructions. Direct care staff interviews revealed residents may use the telephone, located on each unit, to privately report sexual abuse and sexual harassment. The telephone was tested during the site tour and was found to be in working order.

The residents also identified internal ways a resident may report such as completing a PREA/grievance form; talking to a trusted staff member; completing a Medical Request Form; or tell an outside person or family member. There are designated locked boxes and forms on the living units for depositing the written grievance forms. If a resident uses a grievance form to report allegations of sexual abuse or sexual harassment, he/she just needs to place his/her name on the form, check the appropriate space and place it in the grievance box.

The resident receives a Safety Brochure which provides PREA related information, including how to report allegations of sexual abuse. Posters are located in the living units and other areas visible to residents, staff, contractors and visitors. Residents revealed they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings

Provision (b):
The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

The OIHH FOP PREA requires youth to have one way of reporting sexual abuse and sexual harassment to a public or private entity or office not a part of the agency. Residents may call the Florida Abuse Hotline or call the victims' advocate hotline. Residents may request to use a telephone with some degree of privacy to call the hotline without having to obtain staff permission and that mandates staff not to question residents about the reason for the call. A resident can request writing materials to write and send a letter to one of these sources.
Random residents interviewed were aware of the abuse hotline and were able to articulate how they could gain access.

Residents may use of the emergency telephone located on each unit. The resident may select the appropriate line and dial a number to reach a victim advocate at the Treasure Coast Center to report an allegation of abuse and/or request advocacy services. Signs are posted explaining how to access the Treasure Coast Center and contains non-emergency numbers for agencies, including the Sheriff's Office. The resident is also instructed on the signage to dial 911 for emergencies. Direct care staff revealed staff could use the emergency phone to report allegations of abuse. Allegations of sexual abuse have not been reported during this audit period. The facility does not detain residents solely for civil immigration purposes.

Provision (c):
Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to document verbal reports. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a PREA/grievance or Medical Request Form, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members interviewed were aware of their duty to receive and document third-party reports.

Provision (d):
The facility shall provide residents with access to tools necessary to make a written report.

Writing materials are readily available for residents to complete the accessible forms. Prior to the site visit pictures were sent to the Auditor showing the reporting forms such as PREA/Grievance forms and Medical Request Forms and the accessibility of writing utensils. During the site visit and while on the site review, the Auditor observed the accessibility of writing utensils to the residents.

Provision (e):
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of the telephone on the living units; use of telephone in an office; third-party reporting form online; report by email to administrative staff; and/or talk to supervisor in private.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting. The residents have multiple internal ways for to privately report. Reports can be made verbally, in writing,

anonymously, and from third parties. A youth may also call or write his/her parent(s) or guardian or call or write his/her attorney or legal representative. Verbal reports would be documented immediately. Residents have access to pens and pencils to write a grievance or complete a Medical Request Form. Staff can privately report sexual abuse and sexual harassment of residents.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from

this standard.) ☐ Yes ☐ No ☒ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative
The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Resident Brochure
Inspector General statement

Interviews:
Facility Administrator
PREA Compliance Manager

OIHH FOP PREA states the facility is exempt from this standard because it does not have administrative procedures in place for residents to report allegations of sexual abuse and sexual harassment through the grievance procedure.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
MOU, The Treasure Coast Center
PREA Brochure (Safety Pamphlet)
PREA Notification/Acknowledgement Form
Posted Information

Interviews:
Residents
Facility Administrator
PREA Compliance Manager
Advocate, advocacy agency

Provision (a):
The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

OIHH FOP PREA ensures residents are provided access to outside confidential support services. The facility has an MOU with the Treasure Coast Center which provides the following: a 24/7 hotline staffed by certified victim advocate; certified victim advocates to respond to requests for advocacy and accompaniment during forensic examination; counselling; follow- up support; and referral for treatment after release or transfer to another facility. Signs containing the Treasure Coast Center hotline number and basic information about the service were observed throughout the facility.

Contact information for advocacy services is a part of the PREA education sessions and is also provided to each resident in the PREA brochure. Information is also provided through signs and posters in various parts of the facility including each living unit. The resident interviews revealed their knowledge of the advocacy services available to them and the limitations of confidentiality. The hotline telephone was observed in each living unit and the contact information for services from the agencies was posted. The telephone was tested and deemed in working order.

Provision (b):
The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The FOP addresses confidentiality of the advocacy support services. The resident receives information regarding the limitations of confidentiality during the intake process. An acknowledgement statement specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by The Treasure Coast Center. Samples of acknowledgement statements were reviewed.

Provision (c):
The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The FOP states the facility has a MOU with the advocacy agency, available by telephone to the resident for access to outside confidential support services. The resident may use the phone, located on each living unit, and push the appropriate number to gain access and speak with a victim advocate. The agency is identified on the signage along with directions for reporting allegations or requesting advocacy services. The Facility Administrator confirmed the availability and accessibility of outside confidential support services to residents. A staff member of the advocacy agency stated that an advocate would go to the facility or the hospital upon request.

Provision (d):
The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The interviews confirmed residents have access to attorneys and court workers and reasonable access to their parents/legal guardians. The site tour revealed areas where residents could meet privately with a legal representative and the visitation area for visits with family members. All residents interviewed stated family could visit and they provided the days and times of visitation and for phone calls.

Residents interviewed confirmed the facility would allow them to see or talk with their lawyer,

another lawyer or a court representative privately. Residents interviewed confirmed the facility would allow them to see and talk with their parents or someone else, such as a legal guardian. Visitors to the facility are informed of PREA and an acknowledgement statement is signed. A sample of PREA Acknowledgement forms were reviewed, including that of an attorney. The Facility Administrator confirmed the facility provides residents with reasonable and confidential access to their attorneys or court representatives and reasonable access to parents or legal guardians. Based on interviews with residents and the Facility Administrator, the evidence shows the facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident access to outside confidential support services and legal representation.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)

Facility Operating Procedures (FOP) PREA
Acknowledgement Statements
Third Party Reporting Form
Multilingual Posters

Interviews:
Random Staff
Residents

§115.354
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

FDJJ's website provides the public with information regarding third-party reporting of sexual abuse or sexual harassment on behalf of a resident. Resident interviews revealed their awareness of reporting sexual abuse or sexual harassment to others outside of the facility including their parents/legal guardians.

FDJJ Policy 1919 PREA and OIHH FOP PREA addresses third-party reporting and interviews revealed random staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to immediately document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline or a third-party reporting form.

All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third party reports such as file an emergency grievance, report to staff or a family member, or utilize the abuse reporting hotline telephone.

Information regarding reporting is provided through observed postings located in various areas of the facility accessible to visitors, residents, staff, contractors and volunteers. The facility's website contains information regarding third-party reporting of allegations of sexual abuse. The Third-Party Reporting Form is observed to be located on the website. Copies of the Third-Party Reporting form are maintained in the lobby and the reporting information is provided to parents/guardians. There were no third- party reports received during this audit period.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance regarding third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee

promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third- party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Florida Administrative Rule 63F-11
Multilingual Posters

Interviews:
Random Staff
Medical Staff/Nurse
Mental Health Staff/Counselor
Facility Administrator

PREA Compliance Manager

Provision (a) and (b):
The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Provision (b): The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

According to the OIHH FOP PREA and the Florida Administrative Code Rule 63F-11, all staff members are required to report any allegation of sexual misconduct or youth-on-youth sexual activity to the Central Communications Center (CCC). The Policy further states that staff is prohibited from revealing any related information to anyone other than those persons making treatment, investigation, security, or management decisions. The Policy also states that staff members are to 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 have contributed to an incident or retaliation. This information should be reported to the CCC, Department of Children and Families Abuse Registry, and local law enforcement. Staff interviews support the standard requirement.

Provision (c):
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

FDJJ Policy 1919 PREA and OIHH FOP PREA supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Based on the review of documentation and interviews with staff, it is evident the facility follows this provision of the standard.

Provision (d):
(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.
(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The medical and mental health staff interviewed stated residents are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. The clinical staff interviewed revealed they are mandated reporters. They also indicated informed consent would be documented for a resident 18 years old and over regarding reporting allegations of sexual abuse that did not occur in an institutional setting.

Provision (e):
(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.
(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.
(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Allegations of sexual abuse will be made by the Facility Administrator/designee which includes but is not limited to the Okeechobee Sheriff's Office. The interview with the Facility Administrator confirmed if the resident is under the custody of a child welfare agency, the Case Worker will be notified. This information was also verified through Policy review and the interview with the Facility Administrator.

Provision (f):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

FDJJ Policy 1919 PREA and OIHH FOP PREA states that all allegations of sexual abuse and sexual harassment information should be reported to the CCC, Department of Children and Families Abuse Registry, and local law enforcement. Staff interviews support the standard requirement.

Conclusion:
The interviews with random staff, mental health and medical staff and Facility Administrator revealed their awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations or incidents. The random staff interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately. The facility staff members are also required by the Policy to report allegations that were made anonymously or by a third-party. During this audit period, there were no allegations of sexual abuse.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Vulnerability Assessments
Inspector General Directive

Interviews:
Facility Administrator
PREA Compliance Manager
Random Staff

§115.362
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

The OIHH FOP PREA addresses this standard and provides that when the facility learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. There have been no incidents in the last 12 months where the facility took any action regarding a resident being in substantial risk of imminent sexual abuse, as revealed in interviews with the Facility Administrator and random staff. Policy guides the response to this standard if it becomes necessary.

The interviews with the residents revealed during the intake process, how they feel about their safety is part of the inquiries by staff in completing paperwork. A review of a sample of

Vulnerability Assessments supports the information provided by residents. The Facility Administrator report during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse. The Checklists regarding the investigations of allegations serves to assist the investigator in ensuring the required protocols are followed.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard and the provisions regarding agency protection duties.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA

Interviews:
Facility Administrator

Provisions (a), (b), (c), and (d):
Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c)The agency shall document that it has provided such notification. (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

OIHH FOP PREA requires the Facility Administrator to notify the head of another facility within 72 hours upon receiving an allegation a resident was sexually abused while confined at another facility. If any allegation is made, the notifications and documentation of the notifications would be made according to facility policy.

During the past 12 months, there were no allegations received a resident was abused while confined to another facility nor were there allegations of sexual abuse received by OIHH from other facilities.

Conclusion:
Based upon the information received and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to other confinement facilities.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff

member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
OIHH Coordinated Response

Interviews:
Random Staff

Provision (a):
Upon learning of an allegation that a resident was sexually abused, the first staff member to

respond to the report shall be required to:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

OIHH FOP PREA provides that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to:
a. Separate the alleged victim and abuser;
b. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
c. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence.

The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There were no allegations that a resident was sexually abused in the last 12 months.

Provision (b):
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

Random staff interviews revealed considerable knowledge of actions to be taken upon learning a resident alleges being sexually abused.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding staff first responder duties.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
OIHH Coordinated Response

Interviews:
Facility Administrator
Random Staff

§115.365
The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

FDJJ Policy 1919 PREA and OIHH FOP PREA require the development of a written plan to coordinate actions taken in response to an incident of sexual assault among staff first responders, medical, and facility leadership. The facility's coordinated staff response plan was reviewed and found in compliance with the standard.

Interviews with the Facility Administrator and random staff revealed they are knowledgeable of their duties in response to an allegation of sexual abuse. The random staff interviewed was familiar with the roles regarding the response to an allegation of sexual abuse. The Facility Administrator discussed the coordinated actions in response to an incident of sexual abuse which was parallel to Policy.

Forensic medical examinations will be provided free of charge to the victim at the Raulerson

Hospital by a Sexual Assault Nurse Examiner (SANE). The hospital has 24/7 access to a SANE provider. A qualified medical professional shall perform a forensic medical examination if there is no SANE available as stated in the hospital's Sexual Assault Policy. The victim will be provided unimpeded access to crisis intervention and medical services.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse. No allegations of sexual abuse have been reported during this audit period.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☐ Yes ☒ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ Exceeds Standard **(*Substantially exceeds requirement of standards*)**

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

FDJJ is not a collective bargaining agency; therefore, this standard is not applicable as

confirmed by the Superintendent and included in the PREA Pre-Audit Questionnaire.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded,

for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Comprehensive Accountability Report
Facility Organizational Chart

Interviews:
Retaliation Monitor
Facility Administrator
PREA Compliance Manager

Provision (a):
The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

FDJJ Policy 1919 PREA and OIHH FOP PREA require the protection of residents and staff who have reported sexual abuse or harassment or who have cooperated in a sexual abuse or sexual harassment investigation. The policy requires the monitoring to take place for a period of 90 days or longer, as needed.

The Facility Administrator serves as the Retaliation Monitor and his interview revealed he is knowledgeable of the position's responsibilities. He articulated multiple measures available for victims, abusers and staff such as housing changes, transfers, reassign staff, etc. FDJJ has developed a form to document monitoring.

There was no retaliation monitoring in the past 12 months.

Provision (b):
The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

The Policy identifies measures to protect staff and residents including the following:
a. Initiating housing changes or transfers for resident victims or abusers;
b. Removing alleged staff or resident abusers from contact with victims; and
c. Providing emotional support services.

The interview confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The PREA Compliance Manager identified protective measures that are aligned with the FOP and standard, including separating the alleged abuser from the alleged victim.

Provision (c):
For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program

changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

FDJJ Policy 1919 PREA and OIHH FOP PREA requires the monitoring of items identified in this provision of the standard. The PREA Compliance Manager explained during the interview how he would discharge those duties, including monitoring the items identified in the standard and whether a resident filed a grievance alleging sexual abuse or sexual harassment. Retaliation monitoring would occur for 90 days to see if there are any changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation, according to Policy. The monitoring will continue beyond ninety (90) days, if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):
In the case of residents, such monitoring shall also include periodic status checks.

The PREA Compliance Manager indicated status checks would be initiated with staff and residents. The FOP states periodic status will occur. The Retaliation Status Checklist would be used to document the status checks as well as the Retaliation Monitoring Checklist to document the ongoing motoring and use of the Retaliation Status Checklist.

Provision (e):
If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

The FOP states if any other individual who cooperates with an investigation expresses the occurrence retaliation from another resident or staff member, OIHH shall take appropriate measures to protect that individual against retaliation.

Provision (f):
An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The FOP states the facility's obligation to monitor shall terminate if it is determined that the allegation is unfounded.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA

Interviews:
Facility Administrator
Mental Health Staff
Medical Staff

§115.368
Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of §115.342.

OIHH FOP PREA requires residents may only be restricted to his/her single room as a last measure to keep a resident who alleged sexual abuse safe and then only until an alternative means for keeping the resident safe can be arranged. No residents have alleged sexual abuse in the past 12 months. The Facility Administrator's interview confirmed compliance with this standard.

FDJJ Policy 1919 PREA and OIHH FOP PREA provides that residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping a resident safe can be arranged. During the isolation period, the resident must have access to daily large muscle activities and legally required educational programming or special education services. FOP further provides for daily visits by mental health and medical personnel. Residents shall also

have access to other programs and work opportunities to the extent possible. According to the Facility Administrator, isolation or segregated housing has not been used to protect a resident who alleged sexual abuse. The medical and mental health staff, Nurse and Counselor, stated they are not aware of an incident regarding sexual abuse or sexual harassment. The clinical staff confirmed in such case, the resident would be visited at least daily.

Conclusion:
Based upon the review and analysis of Policy, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding post-allegation protective custody.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected

perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Inspector General Directive

Interviews:
Facility Administrator
PREA Compliance Manager
Random Staff

§115.371
Provision (a):
When the agency conducts its own investigations into allegations of sexual abuse and sexual

harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Provision (b):
Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334.

Provision (c):
Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Provision (d):
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

Provision (e):
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Provision (f):
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

Provision (g):
Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Provision (h):
Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Provision (i):
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

Provision (j):
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section

for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

Provision (k):
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Provision (l):
Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

Provision (m):
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

OIHH FOP PREA states FDJJ does not conduct criminal investigations of residents' allegations of sexual abuse. The Okeechobee Sheriff's Office and the Florida Department of Children and Families Services handle criminal investigations. FDJJ's Office of Inspector General (OIG) reviews allegations to identify any misconduct by staff related to FDJJ regulatory guidance. The policy also states the agency does not terminate an investigation solely because the source of the allegation recants the allegation.

The agency retains all written reports of investigations pertaining to administrative and criminal investigations.

There have been no substantiated allegations of sexual abuse since the last PREA audit. The interviews confirmed what the practice will be in accordance with the Policy, FOP, and standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding criminal and administrative agency investigations.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Inspector General Directive

Interviews:
Facility Administrator
PREA Compliance Manager

§115.372
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

OIHH FOP PREA states the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of misconduct by staff are substantiated.
The interview with the Facility Administrator and review of the Directive from the OIG was aligned with the FOP.

Conclusion:
Based upon the review and analysis of the available evidence and the interviews, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative investigations.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been

determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Comprehensive Accountability Report
Inspector General Directive

Interviews:
Facility Administrator
PREA Compliance Manager

Provision (a):
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

FDJJ Policy 1919 PREA and OIHH FOP PREA require at the conclusion of any law enforcement investigation into sexual abuse, the victim or the victim's parent(s) or legal guardian(s) shall be notified the investigation has concluded. The Statewide PREA Coordinator will send a letter notifying residents/parents /legal guardian of charges and of the outcome of the investigation including the identification of the investigative entity and state the findings.

The Facility Administrator's interview confirmed his knowledge of the policies and the requirements of this standard. There has been no criminal investigation completed during the past 12 months.

Provision (b):
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The Statewide PREA Coordinator will send a letter notifying residents/parents /legal guardian of charges and of the outcome of the investigation including the identification of the investigative entity and state the findings.

Provision (c):
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed of the following, unless it has been determined that the allegation is unfounded, whenever:
a. The staff member is no longer assigned within the resident's housing unit;
b. The staff member is no longer employed at the facility;
c. The staff member has been indicted on a charge related to sexual abuse within OIHH; or
d. The staff member has been convicted on a charge related to sexual abuse within the facility.

Provision (d):
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The Policy provides that following a resident's allegation that he has been sexually abused by another resident, the alleged victim shall be subsequently informed whenever:
a. The alleged abuser is criminally charged related to the sexual abuse; or
b. The alleged abuser is adjudicated on a charge related to sexual abuse.

Provision (e):
All such notifications or attempted notifications shall be documented.

The Statewide PREA Coordinator will send a letter notifying residents/parents /legal guardian of charges and of the outcome of the investigation including the identification of the investigative entity and state the findings.

Conclusion:
The interviews with the identified staff confirm the Policy requirements and their knowledge of the process of reporting to a resident regarding the outcomes of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to residents.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Employee Handbook

Interview:
Facility Administrator

Provision (a):
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

FDJJ Policy 1919 PREA and OIHH FOP PREA require staff disciplinary sanctions up to and including termination for violating facility's sexual abuse or harassment policies. The policies also mandate the violation be reported to law enforcement and states termination shall be the presumptive disciplinary sanction for staff who engaged in sexual abuse.

The interview with the Facility Administrator, who performs personnel duties, confirmed the FOP.

No employees were terminated or disciplined in the past 12 months for violation of the facility's sexual abuse or harassment policies.

Provision (b):
Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

The FOP states that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident as confirmed by the Facility Administrator.

Provision (c):
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

FDJJ Policy 1919 PREA and OIHH FOP PREA provides that disciplinary sanctions for violations of OIHH FOP relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Provision (d):
All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

OIHH FOP states all terminations for violations of the facility's sexual abuse or sexual harassment policies, or staff resignations related to violations of this policy, shall be reported to law enforcement, unless the activity is clearly not criminal. In addition, it shall be reported to relevant licensing bodies.

Conclusion:
Based upon the review of Policy, FOP, and interview, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Employee Handbook

Interviews:
Facility Administrator
PREA Compliance Manager

Provision (a):
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

FDJJ Policy 1919 PREA and OIHH FOP PREA require any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Policies also require contractors and volunteers who engage in sexual abuse be reported to law enforcement and to relevant licensing bodies. During the past 12 months, there were no allegations of sexual abuse or sexual harassment regarding contractors or volunteers.

A review of training acknowledgement statements and training materials revealed the facility takes measures to provide volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited and is a serious breach of conduct. The review of materials confirmed participation in PREA training and awareness of the zero-tolerance policy and how to report allegations of sexual abuse or sexual harassment of residents.

Provision (b):
The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

FDJJ Policy 1919 PREA and OIHH FOP PREA states the Facility Administrator will take

appropriate remedial measures and consider whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by a contractor or volunteer.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is in compliant with this standard regarding corrective action for contractors and volunteers.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the

offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Document Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Behavior Management Memo

Florida Administrative Rule
Multilingual PREA posters

Interviews:
Facility Administrator
PREA Compliance Manager
Nurse

Provision (a):
A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

FDJJ Policy 1919 PREA and OIHH FOP PREA require an administrative process for dealing with violations of resident-on-resident sexual abuse. The Facility Administrator's interview confirms the formal disciplinary process however residents may also be referred to law enforcement for charges regarding resident-on-resident sexual abuse. Sexual activity between residents is prohibited and court or administrative processes and sanctions occur after determination the sexual activity was coerced. Residents will be disciplined for sexual contact with staff only when it has been determined the staff member did not consent to the sexual contact.

FDJJ Policy 1919 PREA and OIHH FOP PREA provide anyone reporting in good faith will not receive any repercussions. The policies and interview with the mental health staff confirms 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 a sexual abuse incident. The interview also revealed any type interventions or treatment services provided are not as a condition for the resident to access participation in the behavior management system, education services, or other programs.

The Policy addresses an administrative process for dealing with rule violations and references the policy that deals with discipline. Sanctions are directly related to the seriousness of the negative behavior. The interview with the Facility Administrator revealed the process regarding allegations of resident-on-resident abuse which can include the resident being removed from the facility and placed in the detention center during the investigation by law enforcement.

Provision (b):
Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

OIHH Policy provides that disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the extreme event a disciplinary sanction results in the isolation of a resident, OIHH shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Policy further provides for daily visits by mental health and medical personnel. Residents shall also have access to other programs and work opportunities to the extent possible and receive daily visits from medical and mental health staff, in accordance with FOP.

Provision (c):
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The OIHH FOP provides that the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. This was confirmed by the interview with the Facility Administrator.

Provision (d):
If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

OIHH FOP provides the facility considers whether to offer the offending resident therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse participation. The facility may require participation in such interventions as a condition of access to privileges, but not as a condition to access to general programming or education.

Provision (e):
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

OIHH Policy provides the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Provision (f):
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The OIHH FOP states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Provision (g):
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The FOP prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Court processes occur after determination the sexual activity was coerced.

Conclusion:
There have been no residents placed in isolation as a disciplinary sanction for sexual abuse in the past 12 months. Additionally, there have been no administrative or criminal findings of resident-on-resident sexual abuse in the past 12 months. Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding interventions and disciplinary sanctions for residents.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?

☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Youth VSAB Examples
Florida Administrative Rule
Critical Alerts Curriculum

Interviews:
Staff Responsible for Risk Screening
Medical Staff
Mental Health Staff

Provision (a) and (b):
If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Provision (b): If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

FDJJ Policy 1919 PREA and OIHH FOP PREA require a follow-up meeting with a medical or mental health practitioner within 14 days when a resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with the medical and mental health staff and a review of documentation revealed residents are generally seen by medical and mental health staff on the same day of admission as part of the intake process. The policies verify information related to sexual victimization or abusiveness which occurred in an institutional setting is limited to those staff where it is based on their need to know to make the appropriate management and security decisions.

Interviews with the medical and mental health staff and observations revealed documentation of the services provided to each resident is maintained in medical and clinical files. Medical and mental health staff discussed their knowledge of informed consent, in accordance with policy. The facility utilizes a consent form regarding treatment services for residents 18 years old and up. The age range of residents admitted to the facility is 13-18 years old. This information was also confirmed through the interview with the Intake Staff.

Provision (c):
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

The FOP supports that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. The Auditor observed the resident files maintained in a secure manner. The files are secured in a locked cabinet behind a locked door, when the office is unoccupied.

Provision (d):
Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

The FOP provides that medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18. The facility has created the Informed Consent form to document this type of situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding medical and mental health screenings; and history of sexual abuse.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Samples of Acknowledgement of PREA Education
MOU, The Treasure Coast Center
Medical-Mental Health Contract

Interviews:
Medical Staff
Mental Health Staff
Facility Administrator

Provision (a):
Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

FDJJ Policy 1919 PREA and OIHH FOP PREA mandate youth victims of sexual abuse receive timely and unimpeded access to onsite and offsite emergency medical treatment and crisis intervention services, the nature and scope as determined by the judgement of medical and mental health professionals. Medical and mental health staff interviews confirmed emergency medical care and crisis intervention services will be provided by medical and mental health staff as required.

Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate. Observations revealed medical and mental health staff members maintain secondary materials that document services to residents and these staff are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policies and understood by the medical and mental health staff treatment services will be provided at no cost to the victim, whether or not the victim cooperates with the investigation.

There have been no resident victims of sexual abuse in the past 12 months.

Residents are provided access to an outside victim advocacy agency for services through a MOU with the Treasure Coast Center which includes but is not limited to emotional support and accompaniment through the forensic examination and investigative interviews. The advocate will go to the facility or the hospital to provide services. Review of medical files shows that medical and mental health staff members maintain secondary materials and documentation of resident encounters. There have been no allegations of sexual abuse during this audit period.

Provision (b):
If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners.

The interviews with clinical staff revealed residents have unimpeded access to emergency services. The FOP and the written coordinated response plan flow chart provide guidance to staff in protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. The on-call medical list has the names of medical staff and their emergency contact number. The full-time Nurse is generally on-call 24/7 as determined by the interview. Review of the coordinated plan; observations of the interactions among residents, medical and mental health practitioners; and staff interviews indicated unimpeded medical and crisis intervention services will be available to a victim of sexual abuse. There have been no allegations of sexual abuse during this audit period.

Provision (c):
Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The FOP and interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate. Additionally, follow-up services as needed will be provided by the facility's medical and mental health staff, according to the interviews with clinical staff. The facility houses males only.

Provision (d):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The FOP states treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. This was also confirmed through staff interviews.

Conclusion:
Facility Policy revealed emergency services will be provided by medical and mental health staff. The medical and mental health staff interviews revealed they are knowledgeable of actions to take regarding an incident of sexual abuse. It is documented through FDJJ Policy 1919 PREA and OIHH FOP PREA and understood by the medical and mental health staff that treatment services will be provided at no cost to the victim. Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding access to emergency medical and mental health services.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Vulnerability Assessment: Risk of Victimization and/or Sexual Aggressiveness
Florida Administrative Rule
Medical-Mental Health Contract

Interviews:
Medical Staff
Mental Health Staff
Facility Administrator

Provision (a):
The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

OIHH FOP PREA requires mental health evaluation and treatment, as determined by medical/mental health staff, be offered to residents who disclose prior sexual victimization or perpetrated sexual abuse during intake screening. Treatment services are provided at no cost to residents.

There have been no sexual assault victims in the past 12 months; however, if needed, procedures are in place as verified during staff interviews.

The FOP requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. According to the interviews, medical and mental health staff members are aware of the FOP mandates. The FOP and interviews support medical and

mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate, including assessments and therapy.

Provision (b):
The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services; medication management, if prescribed; individual counseling; trauma group; and referrals as needed. The FOP states that follow-up services will be provided.

Provision (c):
The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Provision (d):
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Provision (e):
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

FOP, staff interviews and observations revealed medical and mental health services are consistent with the community level of care.

Provision (f):
Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Testing would be done at the Raulerson hospital and follow-up services may be done at the facility, as needed.

Provision (g):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

All treatment services will be provided at no cost to the victim, according to FOP and staff interviews.

Provision (h):
The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Facility Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the Vulnerability Assessment.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA

Interviews:
Facility Administrator
Incident Review Team Member

Provision (a):
The facility shall conduct a sexual abuse incident review at the conclusion of every sexual

abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

FDJJ Policy 1919 PREA and OIHH FOP PREA require an incident review team meeting within 30 days of the conclusion of each investigation. The policy mandates review team participation to include the agency-wide PREA Coordinator, the facility's PREA Compliance Manager, regional office staff, Facility Administrator, medical and mental health staff. The FDJJ's PREA Coordinator will prepare a report of the review team's findings and submit the report to the Assistant Secretary for Detention Services, regional office staff and the Superintendent.

The interview with the Facility Administrator and a review of the form used to document the incident review team's findings indicate the team: consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility; examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

Provision (b):
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

The FOP requires that the reviews occur within 30 days of the conclusion of the investigation. Although there has not been an allegation of sexual abuse, the Facility Administrator confirmed incident reviews would occur within 30 days of the conclusion of an investigation in accordance with facility FOP and the standard.

Provision (c):
The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The FOP identifies the incident review team members as administrators with input from line supervisors, investigators, medical staff, and Counselors. The investigators from the Okeechobee Sheriff's Office would be invited to the meeting. The interview with the Facility Administrator confirmed the FOP requirements.

Provision (d):
The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at

the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1) -(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA Compliance Manager.

Provision (e):
The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the Facility Administrator, review of FOP and documentation method confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation, including: considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex; other group dynamics; assessment of the area relative to the allegations; and adequacy of staffing.

The FOP requires the meeting to be documented, including recommendations and the document provided to the Facility Administrator. The interview with the Facility Administrator/Incident Review Team Member confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. He confirmed the team would consider all factors required by the standard. A sexual abuse incident review has not been conducted during this audit period. There were no allegations of sexual abuse in the past 12 months.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding sexual abuse incident reviews.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?

☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facilitywith which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA

PREA Data (Annual Report)
CCC Uniform Definitions

Interview:
Facility Administrator
PREA Compliance Manager

Provisions (a) & (c):
The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

FDJJ has developed a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual assault. The instrument includes the data necessary to answer all questions from the most recent version of the Survey of Sexual violence conducted by the Department of Justice. FDJJ Policy 1919 PREA requires CCC to collect all data relating to PREA. FDJJ Policy 1919 requires the collection of data though the CCC for every allegation of sexual misconduct which occurs in its state-operated detention centers and its contracted residential facilities. FDJJ's website includes annual data collected for fiscal years 2013-2014, 2014-2015, 2015-2016, 2016-2017, and 2017-2018.

Provision (b):
The agency shall aggregate the incident-based sexual abuse data at least annually.

The FOP and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (d):
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility maintains and collects various types of identified data and related documents regarding PREA. The facility collects and maintains data in accordance with Policy directives and FDJJ and aggregates the data which culminates into an annual report.

Provision (e):
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

OIHH does not contract with outside facilities for confinement of its residents.

Provision (f):
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The FOP states that upon request, OIHH shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. A request was not made for the previous calendar year.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and

security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Annual Report

Interviews:
Facility Administrator
PREA Compliance Manager

FDJJ 1919 and the OIHH FOP PREA address this standard. The statewide PREA Coordinator will review the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives. The Policy also states that an annual report will be prepared. A review of documentation confirms this practice.

The annual report is approved as required by Policy, per the interviews and a review of the report was conducted by the Auditor. The annual report reflects a comparison of the results of annual data, by calendar year. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Documents Reviewed:
Agency Policy (FDJJ 1919), Prison Rape Elimination Act (PREA)
Facility Operating Procedures (FOP) PREA
Annual Report

Interviews:
Facility Administrator
PREA Compliance Manager

FDJJ Policy 1919 PREA requires the collection of data though the CCC for every allegation of sexual misconduct which occurs in its state-operated detention centers and its contracted residential facilities. All collected data is maintained for a ten-year period as required by the State of Florida's records and retention schedule. According to the FOP, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility was observed to be securely stored.

Conclusion:
Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (N/A before August 20, 2016.)
  ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited? ☒ Yes ☐ No

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?
  ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents, residents, and detainees?
  ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

Since August 20, 2013, FDJJ has ensured one-third of all operated detention centers and all contracted residential facilities have been audited as evidenced by the Final Audit reports provided on the Agency's website.

The Auditor was provided complete access to the facility and observed all areas of the facility's buildings and grounds. Additionally, all relevant documents were provided upon request.
The facility made space available for private staff and resident interviews. Residents were provided information on the "Notice of the Auditor's Onsite Visit" regarding how to send confidential information to the Auditor. No correspondence was received by the Auditor.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a

Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

OIHH meets the requirements of this standard based upon the following evidence:

A review of the FDJJ's website revealed PREA Audit Reports dating back to 2014 through 2018 for detention centers operated by FDJJ and residential facilities contracted by FDJJ are posted and can be downloaded.

This facility was previously audited March 2016 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation; interviews with staff, residents, a volunteer; and observations.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Cheryl M. Anderson — March 12, 2019

Auditor Signature — **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.