PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Fort Myers Youth Academy				
Physical Address: 2515 Ortiz Avenue, Fort Myers, FL 33905				
Date report submitted: February 25, 2016				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
Email: shirleyturner3199@comcast.net				
Telephone number: 678-895-2829				
Date of facility visit: February 1, 2016				
Facility Information				
Facility Mailing Address: 2515 Ortiz Avenue, Fort Myers, FL 33905				
Telephone Number: 239-210-0940				
The Facility is:	☐ Military	☐ County	☐ Federal	
	☒ Private for profit	☐ Municipal	☐ State	
	☐ Private not for profit			
Facility Type:	☐ Detention	☐ Corrections	☒ Other: Residential	
Name of PREA Compliance Manager: Joseph Nixon, Acting Facility Administrator			**Title:**	Dir. Program Support
Email Address: joseph.nixon@us.g4s.com			**Telephone Number:**	239-210-0940
Agency Information				
Name of Agency: G4S Youth Services				
Governing Authority or Parent Agency: NA				
Physical Address: 6302 Benjamin Road, Suite 400, Tampa, FL 33634				
Mailing Address: Same as Physical Address				
Telephone Number: 813-514-6275				
Agency Chief Executive Officer				
Name: James Hill			**Title:**	President
Email Address: jim.hill@us.g4s.com			**Telephone Number:**	813-514-6275
Agency Wide PREA Coordinator				
Name: Bobbi Pohlman			**Title:**	Senior Director of JJDPA/PREA
Email Address: bobbi.pohlman@us.g4s.com			**Telephone Number:**	954-818-5131

AUDIT FINDINGS

NARRATIVE:

Fort Myers Youth Academy is a 28-bed residential facility for male juvenile offenders who have been committed to the Florida Department of Juvenile Justice (FDJJ) and are in need of substance abuse treatment. It is located in Fort Myers, Florida and is operated by G4S Youth Services through a contract with FDJJ. The facility serves residents ranging from 14 to 18 years of age who have been classified as low to moderate risk for placement in a residential environment. The length of stay is from three to nine months for low risk residents and six to nine months for those classified as moderate risk. The facility is accredited by the Commission on Accreditation of Rehabilitative Facilities (CARF).

Residents receive medical and mental health screenings during the intake process and on-going services throughout their stay in the facility. Medical services are provided by the Health Services Administrator, two other Registered Nurses, and there is a contract physician who visits the facility weekly. Mental health services are provided by the Director of Clinical Services and three therapists; a consulting psychiatrist visits the facility weekly. Additional contract positions are psychologist, Certified Behavior Analyst, and a certified addictions professional. Education services, which include academic and career education, are provided through school personnel from the Lee County School District. Residents receive case management services; individual, group and family therapy; substance abuse counseling; recreation therapy; social/life skills training; and academic/career education services.

A Performance Plan of goals and expectations is developed for each resident. Residents are assisted by staff in completing any court sanctions and they are incorporated in the Performance Plan. The sanctions may include but are not limited to community service hours, apology letters, or written essays. Residents are involved in restorative justice education sessions and activities using specific curricula that help residents understand the impact that unlawful behavior has on individuals, families and the community. Information about the Fort Myers Youth Academy is provided to parents/guardians through direct contact, Parent Handbook, program handbook, and a follow-up letter after the arrival of the resident to the facility. A behavior management system, Positive Performance System, exists where a resident may earn advancing levels through earning points for demonstrating positive behavior. Each level has identified privileges that increase with the earning of each advanced level; more responsibility is placed on the resident at each level.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There are three main buildings on the grounds; however, there is one primary building that houses the program. The front of the building contains a reception area, administrative offices and a conference room. Beyond this section of the building is a large area that is divided into the dayroom and the dining room; the kitchen is adjacent to the dining room. There is also a hallway in this area and one end of the hall include the education office and two classrooms; the other end of the hall contains the residents' housing area; medical clinic; bathroom for residents; laundry room; and offices. There are 11 rooms on the housing unit that contain 2-3 residents in each room. The Case Manager and two

mental health therapists are located on the housing unit. Residents are provided a reasonable amount of privacy during showers, while using the toilet, and when changing clothes. PREA related information is posted in various areas of the facility.

There is a large patio/porch on the back of the building and grounds that provide a basketball court and space for recreation and other activities. Behind the primary building is a portable structure which is used as a multi-purpose room for resident and staff activities. There is a third building that has two sides; an office on one side and maintenance on the other side. The office houses the Recreation Therapist's office and the canteen. The canteen is associated with the behavior management system and it is managed by the Recreation Therapist.

Cameras are located in various areas inside and outside of the facility and are primarily monitored by the Assistant Facility Administrator from his desktop system. The number of residents admitted to the facility during the past 12 months whose length of stay was more than 30 days is 47. In the past 12 months there have been four contracts for services with contractors who might have contact with residents. The number of staff employed at the facility in the past 12 months who may have contact with residents is 73 and there are nine volunteers who may have contact with residents.

SUMMARY OF AUDIT FINDINGS:

An introductory conference call was held prior to the site visit and the audit process was discussed with facility staff and the DJJ statewide PREA Coordinator. The notifications of the on-site audit were posted in the facility prior to the site visit and pictures of the postings were forwarded to this Auditor. The Pre-Audit Questionnaire was uploaded to a flash drive with policies and supporting documentation and was received prior to the site visit. There were follow-up communication with facility management staff and additional documentation was requested and provided and information was clarified as needed. The position of Facility Administrator serves as the PREA Compliance Manager. This position is currently vacant; however, the Director of Program Support is serving as the Acting Facility Administrator and the PREA Compliance Manager.

The on-site audit was conducted February 1, 2016. Introductions were conducted with the Acting Facility Administrator and a comprehensive tour of the facility was provided by him and the Assistant Facility Administrator. During the tour, staff members were observed to be providing direct supervision to the residents and interacting with them. Randomly selected residents and staff members who provide direct care to residents were interviewed. Direct care staff members were interviewed from all shifts. Specialized interviews were conducted which included a contractor and a volunteer. During the on-site visit, additional documentation was provided as requested. At the conclusion of the site visit, a close-out meeting was held with the Acting Facility Administrator.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

The facility adheres to Policy 10-25, Prison Rape Elimination Act (PREA) and Policy 1919 of the Florida Department of Juvenile Justice (FDJJ 1919). The policies are aligned and provide guidelines for implementing the strategies for complying with the requirements of the PREA standards. Both policies state a zero-tolerance of all forms of sexual abuse and sexual harassment. The Policies contain definitions of prohibited behaviors and sanctions for those found to have participated in the prohibited behaviors.

Policy 10-25 states that the Facility Administrator or a person designated by the G4S Regional Director serves as the PREA Compliance Manager. The interview with the Director of Program Support and a review of the organizational chart revealed that the Facility Administrator (FA) manages the facility and serves as the PREA Compliance Manager. The Director of Program Support is serving in the roles of Acting FA and PREA Compliance Manager until the vacancy is filled. The interview further revealed that the FA would have sufficient time and authority to implement and coordinate the activities regarding PREA compliance. The FA in the capacity of the Compliance Manager reports to the G4S PREA Coordinator regarding PREA initiatives.

Standard 115.312 Contract With Other Entities for the Confinement of Residents.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 and periodic internal management reviews of the staffing schedule, ensures adequate levels of staffing for all shifts. The contract with FDJJ requires staffing ratios of 1:7

during the waking hours and 1:10 during the sleeping hours and the staffing plan reflect the stated ratios. The interview with the Director of Program Support/Acting FA revealed that the internal reviews of the staff schedule, staff hold-over process, and the use of a pool of "as needed" staff ensures no deviations from the staffing plan. The facility reports that the average number of residents in the facility since August 2012 is 27 and that the average daily number of residents in which the staffing plan was predicated is 28.

A Staffing Plan Assessment was reviewed which was completed by FDJJ's statewide PREA Coordinator and includes a review of the items listed in the standard and other related areas of facility operations. The Staffing Plan Assessment contains a review of the staffing plan; staffing patterns; deployment of cameras; unannounced rounds; operating procedures; and other factors that contribute to maintaining compliance with the staffing plan. Policy 10-25 provides that the Administrative Duty Officer conducts unannounced rounds at least once a month and that the visits are documented in the logbook or the shift report. A review of logbook entries and staff interviews confirmed that unannounced rounds occur as required and are conducted by the FA, Assistant Facility Administrator (AFA) and shift supervisors. The PREA Policy and the facility practice, confirmed through interviews, prohibit staff from alerting other staff of the occurrence of the unannounced rounds. The Acting FA has since adapted a specific form for the facility in order to capture more details of the unannounced rounds and to make the documentation and review of the rounds more accessible.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

This standard is met through a review of Policy 10-3, observations and the results of staff and resident interviews. Staff members and residents revealed that cross-gender pat-down searches and cross-gender strip searches are not conducted at this facility. Policy 10-3 addresses staff conducting searches of residents and provides the details of each type search and the documentation of searches. Although the practice of the facility is that cross-gender searches are not conducted, Policy 10-3 does provide for when a female staff may assist a male by acting as a second person in the search area, observing the staff, while not viewing the resident. The Policy requires that in these circumstances, the reason for the opposite gender assisting in the search must be authorized by the FA and the reason for the search documented. Staff interviews shared that training regarding the searches of all residents includes the techniques as well as conducting them in a professional and respectful manner. The search methods were explained that demonstrates a professional manner for all residents.

Policy 10-25 and resident and staff interviews provide that residents are able to shower, use the toilet, and change clothes without being viewed by female staff. Staff shared that female staff members do not supervise the aforementioned activities. All residents and staff interviewed confirmed that female staff follow the prompting of the observed posted signs and announce themselves when entering the living unit where residents may be showering,

changing clothes or performing bodily functions. It was observed that there were no shower curtains and that the toilets were open with no type closures. The supervision of bathroom activities is supervised by same gender staff, who are strategically placed during showers and use of the toilet. However, in order to provide each resident with a reasonable amount of privacy, the facility implemented a corrective action plan and installed shower curtains at the entrance of the toilets and the showers in a manner that serves this purpose. Policy 8-14 states that transgender or intersex residents shall not be searched or physically examined for the sole purpose of determining their genital status. Staff interviews confirmed their awareness of this Policy and no such searches occurred during this audit period.

Standard 115.316 Residents with Disabilities and Residents Who are Limited English Proficient

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 provides disabled residents the equal opportunity to participate in or benefit from resident education to protect them from sexual abuse and sexual harassment. Residents are not to be used as interpreters or readers, according to Policy 10-25, unless an extended delay in obtaining an interpreter could compromise the resident's safety, the performance of the first responder duties, or the investigation of the resident's allegation. The facility may use the Registry of Certified Court Interpreters as a resource, as well as other G4S staff members who may serve as interpreters. The facility provides an extensive list of internal interpreters which identifies the G4S facility the staff member works in and other contact information as well as the language for which they may provide interpreter services.

The list for the external interpreters, Registry of Certified Court Interpreters, is composed of several pages that contain the contact information as well as the language specialty. Contact information for American Sign Language interpreters is also included in the lists of external interpreters. Interviews with staff confirmed their awareness of staff members who may be used as interpreters and the existence of the list of external interpreters. Staff report that no residents have been used as interpreters during this audit period.

Standard 115.317 Hiring and Promotion Decisions

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 3-16, Employee Recruitment and Selection, and FDJJ Policies 1800 and 1919 address this standard regarding hiring or promoting anyone who has engaged in sexual abuse in a jail, lockup or similar facility; has been convicted of engaging or attempting to engage in coerced

or forced sexual activity; or has been adjudicated for any of the aforementioned activities. The Policies prohibit hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited by the standard and it provides directions regarding background checks and screenings. Any incident of sexual harassment is considered regarding the hiring or promotion of anyone. This was confirmed through the review of the hiring packet and the staff interview.

A review of a sample of personnel files revealed that they include background checks; signed acknowledgement forms regarding PREA related issues and information received; signed disclosure forms; and interview information. The staff interview also revealed that hiring and promotion decisions are based on background information obtained and according to the considerations required by the standards. The policies provide that the omission of information regarding misconduct is grounds for termination of employment. The Business Manager reports that all staff hired during this audit period received background checks and he verbalized his knowledge of the hiring and promotion process.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

In addition to direct supervision, a camera system is used to support the monitoring of residents. The current program has occupied the facility since 2014 and a camera system was already installed. However, since that time the agency has installed additional cameras to the outside recreation area and inside of the Recreation Therapist's office which is located on the outside grounds. The AFA conducts the primary monitoring on the desktop system from his office.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

According to Policies 10-25 and FDJJ 1919 and staff interviews, the elements of the standard are met and facility staff members are not responsible for conducting administrative or criminal investigations. FDJJ 1919 and 10-25 support that the Florida Department of Juvenile Justice Office of the Inspector General (OIG) is responsible for conducting administrative investigations; the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse; and local law enforcement is responsible for

conducting criminal investigations. A review of documentation shows that the facility has shared with law enforcement personnel the FDJJ written information regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011. Documented correspondence shows that the FDJJ PREA information sheet has been shared with the Ft. Myers Police Department.

The facility has provided for victim services, at no cost to the victim, through entering a Memorandum of Agreement (MOA) with a rape crisis center, Abuse Counseling and Treatment Center. Assistance that will be provided by the agency include Sexual Assault Nursing Examiner/Sexual Assault Forensic Examiner services; counseling services; a list of approved victim advocates so that one is available in person when needed; and facility staff training regarding the role of the rape crisis center. The MOA provides that a victim advocate may accompany and provide support to the victim through the forensic medical examination and investigatory processes. An interview with the rape crisis center representative confirmed the content of the MOA and that advocacy services and the forensic examination will be provided to a victim when requested. There have been no forensic examinations conducted during this audit period.

Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25; FDJJ 1919; FDJJ 2020; document review; and staff interviews support that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The Policies identify who is responsible for conducting the criminal and administrative investigations and instructs staff to cooperate with investigations. During the past 12 months there were two administrative investigations of sexual abuse and sexual harassment. The administrative investigations resulted in findings of Unsubstantiated and the other one was closed as Information Only. There is an allegation that involves a criminal investigation that is ongoing by the Collier County Sherriff's Office that did not occur in the facility. According to the incident report and management staff interview, the alleged incident occurred after the resident left the facility and was reported by the youth's community worker. The facility staff member associated with the allegation was placed on suspension by facility management pending the outcome of the investigation; however, the staff member has since resigned. A review of policies and other documents and management staff interview indicate that the allegations were reported, as well as investigated, as required by the standards.

The Florida Department of Juvenile Justice website contains the policy regarding reporting allegations of sexual abuse and sexual harassment. The OIG follows unit specific policy in conducting administrative investigations. Additionally, the facility provides parents/ guardians and visitors with information regarding how they, as well as the residents, may report allegations of sexual abuse and sexual harassment allegations. Staff interviews support policy and the practice that all referrals of allegations for investigations are documented.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policies 5-1 and 5-2 address employee training and staff interviews and a review of the Skill-Pro training documents confirmed the training as required by the standard and includes the facility and agency zero-tolerance policies. Documents and staff interviews also support that PREA refresher training is provided at least annually, and as needed to address specific PREA topics. The facility reports that the training is tailored to the needs of the population they serve and that all staff members have received training as required by the standard. A review of a sample of staff training records and staff interviews support that initial training and refresher training occurs. There is documentation of the receipt of PREA training and the comprehensive PREA training curriculum. Florida DJJ provides on-line training through Skill-Pro and facility in-house training has been conducted regarding specific areas of the standards.

Standard 115.332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919, a review of the training curriculum for volunteers, and documented training support that volunteers and contractors receive training on their responsibilities regarding the zero-tolerance of sexual assault and sexual harassment and how to report any allegations or incidents. Interviews with a volunteer and a contractor confirmed their participation in PREA related training. All volunteers receive a Volunteer Handbook.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

According to Policy 10-25, resident and staff interviews, and a review of documentation acknowledging resident participation in PREA education sessions, all residents are provided age-appropriate PREA information during the intake process. All residents receive PREA education regardless if they are transferring from another facility or are a new admission and

the facility policy addresses retaliation if a resident should report an allegation from a former facility or the current one. Staff members may assist with the PREA education for residents that are limited English proficient, visually impaired, otherwise disabled, or have limited reading skills. Additional support services may be obtained from the Registry of Certified Court Interpreters, Florida Registry of Interpreters for the Deaf, and staff members that work at other G4S facilities. The PREA information is posted within the facility in various locations and program handbooks remain available to all residents. The interviews with the residents showed that they were lacking in their awareness of the specific services that they would be provided by the rape crisis center if they should need them and the confidentiality practices. A corrective action plan was implemented and this auditor received the education roster where each resident had written his name showing that the education session had been conducted by the Acting Facility Administrator, based on the information provided by the agency.

Standard 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses the training of the OIG Investigators, including the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Appropriate training is provided to investigative staff regarding conducting investigations in the DJJ settings. The FDJJ information sheet regarding investigations protocols are shared with local law enforcement by the facility management staff. The facility staff members do not conduct administrative or criminal investigations. Staff interviews confirmed the practice and they are aware of the investigative entities.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

FDJJ 1919 and facility Policies 5-1 and 5-2 address staff training. The medical and mental health staff members have received the training developed for those areas, as well as the initial PREA training. The specialized training is developed by DJJ and is accessible to medical and mental health staffs online and is documented through the Skill-Pro training process. The medical and mental health staff interviewed supported the documented training. The medical staff does not conduct forensic medical examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 9-1, 8-14 and FDJJ 1919 provide information regarding screening for risk of victimization and abusiveness. Staff and resident interviews and a review of documentation also confirmed that residents are screened for risk of victimization and abusiveness within 24 hours of intake, whether a transfer or new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). The VSAB is used to obtain the information required by the standard. The facility reports that 47 residents received the screening during this audit period. Interviews revealed that reassessment screenings are conducted as needed on a formal basis and on an informal basis through resident meetings with treatment staff. The residents that were interviewed were able to indicate some of the questions that are contained in the VSAB.

Standard 115.342 Use of Screening Information

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 9.3, 8-14 and FDJJ 1919 address this standard regarding the information from the VSAB and other risk screening instruments and outline how the information is to be used to help determine housing and program assignments with the goal of keeping all residents safe. No resident has been placed in isolation during this audit period regarding their safety from sexual assault; isolation is not used at this facility. Policy 8-14 prohibit placing gay, bisexual, transgender or intersex residents in specific housing or making other assignments solely based on how they self-identify or their status and also prohibits staff from considering that identification as an indicator that these residents may be sexually abusive. Facility policy and staff interviews support that housing and program assignments for transgender or intersex residents are made on a case-by-case basis.

Standard 115.351 Resident Reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policies 8-3, 10-25 and FDJJ 1919 address this standard and provide multiple internal ways a resident may privately report sexual abuse and sexual harassment, retaliation for reporting, and staff neglect or violations of responsibilities that may lead to the aforementioned incidents. Residents may report allegations of sexual abuse or sexual harassment by telephone, using the abuse hotline 800 number. Staff may also use the abuse hotline to privately report sexual abuse and sexual harassment of residents. There are also additional internal ways a resident may report, such as completing a grievance form; talk to any staff member; complete a Let's Talk form requesting to speak to a specific staff member; and third parties may report allegations. Access to writing tools is provided for residents so that they are able to complete the forms used for reporting or making requests. Resident and staff interviews support the ways a resident may report allegations and the information is also provided in the program handbook.

Staff and resident interviews revealed that they are aware of the policies regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymous, and by third parties. Policies and staff interviews support that staff are required to document verbal reports and to report the information to the Central Communications Center within two hours of receipt of the verbal report. Staff receives this related information through policies and procedures, training and the Employee Handbook.

Standard 115.352 Exhaustion of Administrative Remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 8-4 provides the details regarding completing and responding to a grievance, including an emergency grievance that alleges sexual assault or sexual harassment. Emergency grievances may be completed at any time and may be given to the grievance officer or placed in the locked grievance box. The resident is not required to handle an emergency grievance informally by attempting to resolve the situation with staff. The grievance policy provides for assistance to the resident, by third-parties, in filing the grievance and that grievances may be received by third parties. It must be documented when a resident refuses third-party assistance. A resident's parents or legal guardians may file a grievance on behalf of the resident whether he agrees or not to the grievance being filed.

When an emergency grievance is received, it is immediately provided to the FA, per Policy 8-4. A response is provided to the resident immediately and the policies and procedures for reporting allegations of sexual abuse are initiated and a report is made as required by policy. The facility's grievance system is not intended to provide for an investigation or to resolve allegations of sexual abuse. The content of the grievance is reported and an investigation is conducted by the OIG, DCF or local law enforcement. The purpose of the submission of a

grievance concerning sexual abuse provides an avenue for ensuring the reporting of the allegation and provides management staff with the opportunity to intervene and protect the resident. During the past 12 months, there has not been a grievance filed alleging sexual abuse.

Policy 10-25 and the Employee Handbook provide staff with the required information for reporting sexual abuse and sexual harassment of residents. The agency policy provides that a resident may be disciplined when it has been determined that a grievance alleging sexual abuse has been filed in bad faith. The residents and staff interviewed were able to articulate how the grievance system may be used to report allegations of abuse and the residents are aware of how grievances are handled. This Auditor observed the locked grievance boxes.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 10-25 addresses this standard and requires the Facility Administrator to ensure that residents have access to an outside victim advocacy agency for emotional support services. The resident is provided with general and contact information during PREA education sessions and it is made available through posters as observed by this auditor. There is documentation of a Memorandum of Agreement (MOA) between the facility and a rape crisis center, Abuse Counseling and Treatment Center. The MOA includes how services will be provided to victims in as confidential a manner as possible. Services to be provided that are contained in the MOA were confirmed through a telephone interview with a representative of the rape crisis center. Among other services, the agency will provide residents with an advocate to be present during the forensic examination and investigative processes and will provide emotional support services. According to policy and residents' interviews, the facility provides residents with reasonable and confidential access to attorneys or other legal representation and court workers and reasonable access to their parents or legal guardians. Family Fun Day is held at the facility every quarter and provides planned pleasurable activities for residents and their family members, in addition to visitation.

Standard 115.354 Third-Party Reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policies 8-3 and 10-25 address third party reporting and interviews revealed that residents are familiar with the concept of third-party reporting of sexual abuse and sexual harassment. All residents interviewed stated that they had someone who did not work at the facility that they could report to regarding sexual abuse. Staff interviews revealed their knowledge of third-party reporting. Information regarding reporting is provided through posters that are located in areas of the facility that are accessible to the public, residents and staff members. The FDJJ website contains information regarding third party reporting.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 8-3, 10-25 and FDJJ 1919 provide that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. The direct report of an incident should be reported to the Central Communications Center no later than two hours after receipt of the information. Policy 10-25 prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. A review of incident reports and interviews revealed that staff members are aware of the requirement regarding their reporting duties and understand that they are mandated reporters.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 instructs staff to take immediate action to keep residents safe when they learn that there is substantial risk of imminent threat of sexual abuse. Interviews with staff confirmed their knowledge of this policy and they were able to verbalize measures they would take to protect residents who are at substantial risk of imminent sexual abuse. Some of the protective measures stated that could be implemented immediately were one-on-one staff supervision, room re-assignments and alerting other staff to the situation. Safety tips for self-protection while in the facility are listed in the resident's program handbook. It was determined that during the past year, no resident was at substantial risk of sexual abuse. Residents indicated that during the intake process, their feelings about their safety are explored and they also report that staff will inquire about whether they feel safe in the program during treatment meetings.

Standard 115.363 Reporting to Other Confinement Facilities

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 19-25 and FDJJ 1919 address this standard and requires the Facility Administrator, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The Facility Administrator must also notify the Central Communications Center to report the incident for an investigation. The facility reports that during this audit period, there have not been any reports from a resident about an incident of abuse occurring while they were confined in another facility. The Acting Facility Administrator indicated his awareness of the policy regarding reporting to other confinement facilities and the requirement that allegations received from other facilities must be investigated.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 details the first responder duties which are generally to separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Initial training and a refresher was conducted with staff through a combination of online statewide training and in-house training. Staff interviews revealed that they are aware of the steps to take if they are the first responder. FDJJ 1919 directs that if the employee first responder is not direct care staff, they should request that physical evidence is preserved and direct care staff should be notified. During the past 12 months, a non-direct care staff has not acted as a first responder.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.366 Preservation of Ability to Protect Residents From Contact With Abusers.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and FDJJ 1919 provide protection to residents and staff from retaliation. The retaliation monitor has been identified as the Assistant Facility Administrator (AFA). He understands that he is charged with observing for whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation. Policy 10-25 identifies items to be monitored to determine whether retaliation is occurring. The interview with the retaliation monitor supported the Policy and identified some of the things he would consider in detecting retaliation such as a review of any grievance, review cameras, review the Let's Talk forms, and observe interactions. The AFA reports that there has not been an incident of retaliation during the past 12 months and there was no indication of such.

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

This standard is not applicable. Segregated housing is not used at this facility to house residents who allege sexual abuse.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and FDJJ 1919, staff interviews, and a review of reports provide that administrative investigations are conducted by the OIG and criminal investigations are conducted by the Fort Myers Police Department. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. The Policies direct facility staff to cooperate with investigations and FDJJ 1919 further provides that an investigation is not terminated because the source recants the information. This practice is evidenced through an interview with management staff and through the review of an investigation report. The OIG follows protocols in conducting administrative investigations in FDJJ settings. Facility management staff provided local law enforcement with the FDJJ form regarding the expected protocols related to PREA investigations that are criminal in nature.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 provides that the OIG, responsible for administrative investigations, impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 allows for the victim to be informed that the investigation has been concluded and Policy 10-25 provides that the Facility Administrator notifies the victim or victim's parents or legal guardians. This information is provided to the resident on the Investigation Notification

(PREA) form. A review of the form for a notification made to a resident who reported an allegation, stated the purpose of the notice and the results of the investigation which were Unsubstantiated. The form contains the resident's signature and signature of a staff witness. The form is designed to contain the information required in the standard such as the results of the investigation, whether or not the alleged abuser has remained at the facility, and whether the alleged abuser has been charged or convicted of the crime. The form will also let a resident know if the findings of an investigation were Unfounded.

During the past 12 months there were two administrative investigations; the findings for one allegation was unsubstantiated and the other was closed as Information Only. Regarding the unsubstantiated findings, the written notification of the findings was provided to the resident prior to his release from the facility. The allegation involving a facility staff member regarding an alleged incident occurring after the resident's release to a community placement was made by the youth's community worker. The investigation is ongoing by the Collier County Sherriff's Office and the staff is no longer employed at the facility.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 3-3 provides that disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance policy. The facility reports that during this audit period, it is alleged that one facility direct care staff member has violated FDJJ agency policy regarding sexual abuse or sexual harassment after the youth was released and was in another placement. According to facility policy, management staff placed the staff on suspension pending the outcome of the investigation; the employee subsequently resigned. The investigation is ongoing by the Collier County Sherriff's Office.

Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff. During the past 12 months, no staff member has been disciplined for violation of agency sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies. Agency policy provide that terminations or resignations by staff who would have been terminated if not for the resignation, are reported to local law enforcement if the situation appeared to be criminal in nature and to relevant licensing bodies. The staff interviews revealed knowledge of the personnel policies and practices.

Standard 115.377 Corrective Action for Contractors and Volunteers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses this standard, including requiring that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. It also provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement agencies and to relevant licensing bodies. Policy 10-25 prohibits sexual activity between residents and volunteers and contracted personnel. The facility ensures that volunteers and contractors have a clear understanding that a sexual relationship with a resident is strictly prohibited and is a serious breach of conduct. Interviews with a volunteer and a contractor and a review of the training document confirmed the related orientation and training for volunteers and contractors. A handbook is also provided to volunteers that includes the PREA related information. During this audit period, there have been no allegations of sexual assault or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 8-1 and FDJJ 1919 address the formal administrative process and the measures to be taken regarding major rule violations. This information is also addressed in the program handbook and isolation is not used as a sanction in response to any rule violation. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Sexual activity between residents is prohibited and administrative or court processes and sanctions occur when it has been determined that the sexual activity was coerced. Residents are disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact.

Policy 10-25 states that anyone reporting in good faith shall be immune from any civil or criminal liability. During the past 12 months there have been no administrative findings or criminal findings of guilt regarding resident-on-resident sexual abuse that occurred at the facility. Policies 10-25 and FDJJ 1919 and interviews with mental health and medical staffs support that counseling or other interventions will be offered to address and correct the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after an incident. The staff members interviewed stated that any type interventions or treatment services provided would not be dependent on the resident's participation in the behavior management system, education or other programs.

Standard 115.381 Medical and Mental Health Screenings; History of Sexual Abuse

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 and FDJJ 1919 address all sections of this standard, including providing for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with medical and mental health staff confirmed the practice of residents being generally seen by mental health and medical staff on the same day of the disclosure or discovery. Policy supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and those staff, based on their need to know. A review of files show that medical and mental health staff members maintain documentation of the services they provide to the residents. Medical and mental health staffs discussed their knowledge of informed consent regarding 18 year olds and how it is used and the consent form was reviewed by this Auditor.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 7-30 and FDJJ 1919 address the elements of this standard. Staff interviews and a review of documented practices revealed that crisis intervention services will be maintained by medical and mental health staff as required. Observations of files show that medical and mental health staff members maintain secondary materials that document services to residents and in an incident of sexual abuse the requirement of the standards will be met as demonstrated through interviews and the current records reviewed. It is documented through policies and understood by staff that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and 7-30 and interviews with medical and mental health staff confirmed that on-going medical and mental health care will be provided for sexual abuse victims and

abusers, as appropriate. Policy 10-25; staff interviews; document review; and observations revealed that medical and mental health services are consistent with the community level of care. Policies, interviews and observations also support that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

Standard 115.386 Sexual Abuse Incident Reviews

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 and FDJJ 1919 provide for an incident review to be conducted within 30 days of the completion of an investigation in accordance with the tenets of this standard. During the past 12 months, there were two administrative investigations. One resulted in findings of Unsubstantiated and the other one resulted in findings being labeled as Information Only. A document review and staff interviews show that a sexual abuse incident review was conducted, with documented findings and participants, within 30 days of the completion of the investigation of the allegations that were unsubstantiated.

The incident review report process allows for the inclusion of recommendations and the report is provided to the Facility Administrator, who also serves as the PREA Compliance Manager. The Policies outline the requirements of the standard for discussion and review by the incident review team. The Policies also identifies the positions that comprise the team. The Policies, documentation and staff interviews verify the existence and identity of the Incident Review Team. The identified participants on the team may include the Facility Administrator; Assistant Facility Administrator; facility treatment staffs; direct care staff; statewide FDJJ PREA Coordinator; FDJJ Regional Program Administrator; and other participants as needed. The incident review team member interviewed explained the purpose and the process of the team.

Standard 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 and documentation confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for FDJJ facilities and contractors capture the information required to complete the most recent

version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ). The agency maintains and collects various types of identified data and related documents regarding sexual abuse incidents. FDJJ aggregates the sexual abuse data annually which culminates into an annual report, which has been reviewed by this Auditor. The agency provides DOJ with data as requested.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses the sections of this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. The Policy also states that an annual report will be prepared that will provide an assessment of the agency's progress in addressing sexual misconduct. The annual report is approved as required. It is obvious from staff interviews, observations, and document review that the agency has compared the results of the annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. The annual reports have been reviewed by this Auditor and the report is accessible to the public through the agency's website. There are no personal identifiers on the annual reports.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 provide that all data collected will be securely maintained and for at least 10 years after the initial collection date, unless statutes require otherwise. According to the Policy, the aggregated sexual abuse data from all facilities 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 that there are no personal identifiers, as required.

AUDITOR CERTIFICATION:

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

Shirley L. Turner

Auditor Signature

February 25, 2016

Date