PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: August 16, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
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Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: July 10, 2017			
Facility Information			
Facility name: Kissimmee Youth Academy			
Facility physical address: 2330 New Beginnings Road, Kissimmee, Florida			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 727-420-1947			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Joseph Nixon			
Number of staff assigned to the facility in the last 12 months: 60			
Designed facility capacity: 100			
Current population of facility: 44			
Facility security levels/inmate custody levels: High			
Age range of the population: 14-21			
Name of PREA Compliance Manager: Sumpter James		**Title:** Program Director	
Email address: Sumpter.James @youthopportunity.com		**Telephone number:** 727-420-1947	
Agency Information			
Name of agency: Youth Opportunity Investments			
Governing authority or parent agency: *(if applicable)*			
Physical address: 12775 Horseferry Road, Suite 230, Carmel, IN 46032			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 371-587-8880			
Agency Chief Executive Officer			
Name: Jim Hill		**Title:** Chief Executive Officer	
Email address: Jim.Hill@youthopportunity.com		**Telephone number:** 727-800-3511, ext. 1002	
Agency-Wide PREA Coordinator			
Name: Joseph Nixon		**Title:** Administrator	
Email address: Joseph.Nixon@youthopportunity.com		**Telephone number:** 356-562-2290	

AUDIT FINDINGS

NARRATIVE

The Kissimmee Youth Academy is located in Kissimmee, Florida and provides residential treatment services in a secure setting to male juvenile offenders through a contract between the Florida Department of Juvenile Justice and Youth Opportunity Investments. The facility's capacity is 100 and the population on the day of the site visit was 44. Youth Opportunity Investments has operated the facility since August 2016. The program provides substance abuse overlay services and mental health overlay services for each resident as appropriate. The facility also provides a program for residents with borderline developmental disability and developmental disability. Residents participate in the behavior management system which includes incentives and consequences that promote individualized skill building, appropriate behavior, and accountability. The average length of stay is 9-12 months, depending on the resident's pace of success in completing his individualized treatment plan and goals.

A conference call was held with the Program Director, Florida Department of Juvenile Justice (FDJJ) statewide PREA Coordinator and a program manager from the FDJJ central office prior to the site visit. During the conference call, introductions were made and the audit process was reviewed. Printed signs announcing the site visit and this Auditor's contact information were posted; pictures were taken and sent to this Auditor via email. The areas where the signs were posted were identified and posted in areas that were accessible to the residents, staff and visitors.

The PREA Pre-Audit Questionnaire, policies, and supporting documentation were uploaded to a flash drive and mailed to this Auditor. After an assessment of the information provided, a written review was sent to the Program Director/PREA Compliance Manager, requesting clarification of information and additional documents. There was communication with the Program Director/PREA Compliance Manager during the document review process, as needed. The additional documentation requested was provided prior to the site visit and as requested during the site visit.

The site visit was conducted July 10, 2017 and began with early morning interviews of direct care staff members from the overnight shift. After the initial interviews a comprehensive tour of the facility was conducted by the Program Director and included all areas of the facility and the outside grounds. The staff members were observed providing engaged supervision of the residents. During the comprehensive facility tour, the printed notifications of the PREA site visit were observed to be posted in the areas previously identified with the pictures that were sent to this Auditor.

Ten residents were interviewed and eight direct care staff members were interviewed that covered all three shifts. There were 10 specialized staff interviews conducted and included a contractor. The interviews with staff members and the residents indicated that they had received PREA training. The staff members, contractor and residents were cooperative and were receptive to the interviews. An exit conference was held at the conclusion of the the site visit with the Program Director and a member of the management team. A written agreement exists with a victim advocacy agency for services when requested and contact was made with the agency by phone by this Auditor.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Kissimmee Youth Academy program is located in one building and there are five storage sheds on the outside grounds. The front of the building contains the lobby, reception area where visitors sign in/out, and administrative offices. There are two living units, west side and east side. Each unit has a master control with three connected housing mods with a dayroom in each; three classrooms; multi-purpose room; and a laundry room. Each mod has a fenced recreation area in the back of it that contains a table with benches. One of the unused mods is used as a part of the behavior management system for residents to look at movies and play games. The building also contains offices for treatment staff; medical clinic; dining area; kitchen; conference room; intake area with a fenced sally port; and storage rooms. The outside grounds contain a large basketball court and space for various activities.

The residents are able to change clothes, use the toilets and shower in their mod and use the toilet in other identified areas of the facility with a reasonable amount of privacy. Residents stated that female staff announce their presence when entering the housing mods. The facility has an electronic monitoring system which is monitored from the master control room in each living unit which supplements the direct and engaged supervision provided by direct care staff.

There is a color-coded system that identifies where residents are allowed only with staff and areas where residents are not allowed at all. During the comprehensive tour of the facility, the restricted areas were observed. Additionnally, posters and signs were observed in various areas regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. Sick call and grievance boxes and forms are maintained in the housing mods. Information for reporting abuse is also contained in the Youth/Parent Program Handbook.

The Health Services Coordinator organizes the medical services and also provides medical services along with two other Registered Nurses. A contract physician visits the facility weekly. The medical department operates seven days a week and staff is on-call to the facility 24/7. Forensic medical examinations will be conducted at the local hospital. Mental health services are provided by the Clinical Director; four Therapists; a contract Behavior Analyst; and a contract psychiatrist who visits the facility every other week. There are three Case Managers who collaborate with all disciplines in the planning, facilitation and coordination of services to meet the comprehensive needs of the residents. Academic and vocational education services are provided for each resident by education staff through the Osceola County School Board. Direct care staff members are responsible for the general supervision of the residents and assist in creating and maintaining a positive facility culture. Services are also provided to the residents by the Recreation Therapist and two Transitional Case Managers.

SUMMARY OF AUDIT FINDINGS

There have been no allegations of sexual abuse or sexual harassment since the facility has been managed by Youth Opportunity Investments beginning in August 2016. Administrative investigations are conducted by the Florida Department of Juvenile Justice, Office of the Inspector General and allegations that are criminal in nature are investigated by local law enforcement; allegations of sexual abuse are also reported to the Florida Department of Children and Families. The facility reports that during this audit period there were no deviations from the contracted staffing ratios. During the comprehensive facility tour, the observations confirmed compliance with the staffing ratios at that time.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy, 5-8, is the zero-tolerance policy regarding all forms of sexual abuse and sexual harassment and it outlines the approach for preventing, detecting, and responding to such allegations. The Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919) serves as the overarching and comprehensive policy guide. The facility's policy 5-8 is aligned with FDJJ 1919 and the PREA Standards. Both PREA policies contain definitions of the prohibited behaviors and address sanctions to be used when the PREA related policies are violated. The facility also has other policies that support the PREA initiatives.

The PREA and related policies outline the strategies for addressing the components of the PREA Standards and include the following:
*prevention and responsive planning;
*training and education;
*risk screening;
*reporting;
*official response following a resident report;
*investigations;
*discipline;
*medical and mental care; and,
*data collection and review.

The Program Director serves as the PREA Compliance Manager and confirmed his role during the interview. A review of the facility's organizational chart shows that the Program Director is supervised by the Administrator who serves as the PREA Coordinator for Youth Opportunity Investments, the agency who manages the facility. The Program Director indicated during the interview that he has the time and authority required to fulfill his PREA related duties and discussed the facility's efforts toward achieving compliance. Interviews conducted with random staff also confirmed their awareness of the role of the Program Director as the PREA Compliance Manager.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policies 5-1 and 5-8 address staffing, supervision and monitoring. The Policy outlines the considerations for staffing and provides guidance to staff in adhering to the staffing ratios of the contract of 1:8 for two groups of the population and 1:6 for the other group during the waking hours and 1:10 for all groups of residents during the sleeping hours. The ratios are based on the level of supervison determined appropriate for the population types.

The work schedules and obsevations during the comprehensive facility tour indicated the adherence to the staffing ratios and the facility policies. The staffing plan provides for the staffing ratios to be met. During the interview with the Program Director, information was provided regarding the considerations for the development and maintenance of the staffing plan, including the identification of blind spots and security and program needs.

The annual Staffing Plan Assessment was completed by the FDJJ statewide PREA Coordinator in conjunction with the Program Director and includes but is not limted to a a review of the following: staffing plan; monitoring system; resources available and committed to ensure adherence to the staffing plan; and the occurrence of unannounced rounds. The form summarizing the completion of the assessment is signed and dated by both the Program Director and the FDJJ statewide PREA Coordinator.

The interview conducted with the Program Director, observations, and a review of the the annual Staffing Plan Assessment and other documents verified that the facility complies with the current staffing plan. Policy 5-8 provides for compliance to the staffing plan and that the the deviations from the staffing plan be documented. The facility reports that the average daily number of residents is 46 and the average daily number of residents on which the current staffing plan was predicated is 46. The facility reports that there has not been a deviation from the staffing plan.

Documented unannounced rounds and Policy 5-8 support that unannounced rounds are conducted by higher level and intermediate level staff. The unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment. The form used to document the unannounced rounds provide for recording observations in identified areas. The Program Director stated that his visits are unscheduled and he ensures that staff is not alerting other staff regarding the unannounced visits. Policy supports the practice that staff does not alert other staff when the defined PREA rounds are occurring.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 5-3 and 5-8 provide guidance to staff regarding searches and address the type of searches to be conducted. Cross-gender strip and cross-gender visual body cavity searches are prohibited at the facility. Cross-gender pat-down searches are not permitted, except in exigent circumstances and they must be documented. The interviews with direct care staff members, residents and Program Director confirmed that cross-gender searches are not conducted. While policy addresses exigent circumstances, staff related that for a cross-gender pat-down search to occur, there would be no other options available during an emergency situation.

Staff report having received training in conducting cross-gender searches and the searches of transgender and intersex residents. The review was addressed in a staff meeting and included a presentation regarding such as provided by the agenda and sign-in roster. The Florida Department of Juvenile Justice will inform contract facilities regarding any standardized practices for the searches of transgender and intersex residents. The facility reports that no type of cross-gender searches have been conducted at the facility during this audit period. Searches are conducted and are documented by staff, per the search policy 5-3.

Policy 5-8 prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status; this information was also verified through random staff interviews. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private.

The facility has implemented procedures that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. Random staff and resident interviews, observations and the explained shower and bathroom procedures confirmed the practices for residents being provided reasonable privacy. According to staff and resident interviews, the opposite gender staff announce their presence verbally when entering the resident's living areas. This practice of female staffs making the anouncements was observed during the comprehensive tour of the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 5-8 and FDJJ 1919 address securing support services for disabled residents. The facility staff has access to resources for interpreting, sign language and trilingual services and other support services as determined through a review of documents. Assistance may also be provided by staff, including the assistance of education and mental health staff. The facility has access to PREA education brochures and posters for residents in Spanish.

The facility reports that during the past 12 months there has not been a need for interpreters. The random staff interviews support that the facility does not rely on resident interpreters, resident readers or any type of resident assistants for the provision of PREA information for another resident, as required. Reporting information is posted on the living units and in various areas of the facility.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 3-1 and 5-8 address the hiring and promotion processes and decisions. The policies and interview with the administrative staff, Director's Assistant, provide details regarding the hiring process, completion of background checks, and the grounds for termination. The policies are aligned with the requirements of Policy FDJJ 1919 and provide that background checks occur and child abuse registries are checked prior to employment and that background checks are conducted every five years. A review of a sample of personnel files and the interview with the Director's Assistant, who is responsible for personnel functions, confirmed the practices.

The documents reviewed, staff interview and policy 5-8 revealed that the facility seeks information from applicants regarding previously related sexual misconduct allegations and convictions. The policies prohibit hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor or volunteer, who may have contact with residents, who has engaged in previous sexual misconduct.

The interview confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, select volunteers, or whether to promote an employee. The FDJJ 1919 policy and the interview with the Director's Assistant provide that staff has a continuing duty to report related misconduct and provide that omissions of such conduct or providing false information are grounds for termination.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The previously installed camera system works in conjunction with and enhances direct care staff supervision. The cameras have been strategically placed in consideration for blind spots and to assist staff in keeping residents safe from sexual abuse. The facility has been operated by Youth Opportunity Investments since August 2016 and was already equipped with a camera system.

Staff was observed actively monitoring the system from the control rooms in the living units and demonstrated the various views of the cameras and the monitoring ability for various areas of the facility. There has been no expansion or modification to the building structure under this contractor.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Policy 5-8 and random staff interviews, confirm that the facility staff members are not responsible for conducting administrative or criminal investigations. Policies FDJJ 1919 and 5-8 support that the Florida Department of Juvenile Justice Office of the Inspector General is responsible for conducting administrative investigations; the Florida Department of Children and Families is responsible for conducting allegations of child abuse; and local law enforcement is responsible for conducting criminal investigations.

The Program Director will serve as the contact person with the law enforcement agency. The FDJJ provides each facility written information regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011 that is to be shared with the local law enforcement agency. This information was confirmed during the initial conference call with the Program Director, FDJJ PREA Coordinator and the central office program manager.

A Memorandum of Understanding (MOU) exists between Youth Opportunity Investments and Victim Services Center of Central Florida for the provision of victim advocacy services. Victim services provided include but are not limited to: forensic examination by a Sexual Assault Nurse Examiner; accompaniment through the forensic examination; counseling; follow-up services; and access to the Victim Services Center's 24/7 hotline number. The MOU also outlines the conditions of confidentiality. The reporting information was observed during the facility tour. There have been no allegations of sexual abuse 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)

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

Policy 5-8, interviews with random staff and the Program Director provide that allegations of sexual abuse and sexual harassment will be investigated. Administrative investigations will be conducted by the FDJJ Office of Inspector General's trained investigators and sexual abuse allegations are referred for an investigation to local law enforcement. The Department of Children and Families is also contacted regarding allegations of sexual abuse. During the past 12 months there were no allegations reported.

The facility's and agency's primary PREA policies, 5-8 and FDJJ 1919, direct staff to report all allegations of sexual harassment or sexual abuse and to document the reports. The random staff members are aware of the requirements as verified through their interviews. The FDJJ website provides the information and policy for reporting allegations of sexual abuse and reporting information is also posted in various areas of the facility, accessible to residents, staff and visitors. The Youth Opportunity Investments website also contains PREA information.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Policy 5-8 and FDJJ 1919 addresses PREA related training for staff. The policies, training curriculums and materials, staff interviews, and a review of training rosters document that the staff training occurs and that the required training topics are addressed. All staff interviewed were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment.

Basic PREA training and refresher training are provided to staff, as indicated by acknowledgement forms and the other documentation. The direct care, medical and mental health staffs interviewed reported receiving the PREA training as required. The facility houses males and the training considers the needs of the population served.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 5-8; review of documentation for training for volunteers and contrators, and an interview with a contractor confirmed that the training occurs. The training curriculum specific to volunteers and contractors was reviewed and it was determined that the zero-tolerance policy, 5-8, regarding sexual abuse and sexual harassment is included in the training.

The PREA training informs the contractors and volunteers of their role in reporting allegations of sexual abuse or sexual harassment. The contractors and volunteers are informed of their responsibilities, and based on the services they provide regarding sexual abuse prevention, detection, and response to a PREA allegation.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 5-8 addresses this standard and provides that all residents receive PREA education. The Youth/Parent Program Handbook also provides information to residents on how to report allegations of sexual harassment and sexual abuse. The Case Manager who conducts PREA education with residents explained the process for ensuring that residents receive the information as required. The

residents sign an acknowledgement form indicating that they participate in a PREA education session. Interviews with the Case Manager and residents indicated that the PREA education had been provided.

The resident interviews revealed that they were informed about the meaning of PREA and related information, their rights, and how to report allegations. However, the residents were not as informed regarding the victim advocacy services that are available to them through the victim advocacy agency. A corrective action was implemented and refresher sessions were conducted that focused on the advocacy services and the sessions included all residents. The refresher education sessions for the residents were documented and the residents signed the training roster. The PREA related information is provided to staff in policies, training and staff meetings.

The facility documents its capability of providing the PREA education in formats accessible to all residents and was determined through the interview with the Program Director. The facility has the PREA related information posted in the housing mods, and other areas. The facility has made prior arrangemens for the provision of interpretive and translation services and facility staff may assist residents as needed. The staff interviews confirmed that residents are not used as interpreters or readers for other residents. The facility reports that 53 residents, admitted during this audit period, received comprehensive age-appropriate PREA education.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy FDJJ 1919 and staff interviews confirmed that the facility staff members do not conduct investigations. Administrative investigations are conducted by the Florida Department of Juvenile Justice Office of the Inspector General and criminal investigations are conducted by local law enforcement. Sexual abuse allegations are also reported to the Florida Department of Children and Families.

Policy FDJJ 1919 provides that Office of Inspector General staff be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. The investigators have been trained in conducting allegations in the FDJJ settings. The Program Director will serve as the primary facility contact regarding sexual abuse and sexual harassment investigations.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policies 5-8 and FDJJ 1919 provide that medical and mental healtht staff members are required to receive the regular PREA training and the specialized training available online through the SkillPro training system provided by the Florida Department of Juvenile

Justice. The mental health and medical staff completed the general PREA training that is provided for all staff members which is also available through the SkillPro training system. A review of training records and interviews with the medical and mental health staff confirmed participation in the online training. Forensic medical examinations will not be conducted by the facility medical staff.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 7-3 and 5-8 address the screening for risk of victimization and abusiveness and provide that all youth admitted to the facility be properly screened. Staff and resident interviews and a review of documentation confirmed that residents are screened for risk of victimization and abusiveness. This vulnerability screening occurs during the admissions process, whether the youth is transferred from another facility or is a new admission.

The screening is conducted using the Florida Department of Juvenile Justice's objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). The VSAB is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; the youth's self-identification; current charges and offense history; and intellectual or developmental disabilities. Resident interviews, a review of a sample of completed VSABs and the interview with the Case Manager indicated that the VSAB is administered according to policy.

The facility reports that 63 residents admitted to the facility during this audit period received the VSAB screening. Per the interview with the Case Manager, pertinent information is obtained for completing the VSAB by asking questions of the resident and probing as needed; reading the Probation Officer's and other related reports; and talking to parents or guardians.

Additional screening and assessment tools are used to obtain information to aid staff in meeting the individual needs of the residents. Interviews with residents indicated that residents are asked safety questions periodically by their Case Manager and Therapist. The information from the risk screening is accessible to the clinical team and the files were observed to be securely protected. The residents interviewed were able to identify specific areas that are inquired about in the administration of the VSAB and they could identify the subsequent safety questions that they may be asked.

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)

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Policy 5-8 addresses this standard and provides information to staff on how the information obtained from the screening instrument,

VSAB, be used. The collective information gleaned from the VSAB and other screening instruments assists in determining bed, education and other program assignments. Random staff interviews indicated that protective measures would be taken immediately if it was determined that a resident was at risk for imminent sexual abuse and the responses included separating residents; alerting supervisor and other staff; moving youth to a different mod; and moving resident to a room closer to the staff duty station. Isolation is not used in this facility.

The policy prohibits placing bisexual, transgender or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The policy also prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. Policies 5-8 and FDJJ 1919 and staff interviews support that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis to ensure the resident's health and safety.

The staff members interviewed are aware of the policies that would be implemented when there are transgender or intersex residents within the population. The resident's concern for his own safety is currently taken into account through responses obtained from the administration of the VSAB screening instrument as confirmed through the resident interviews and a review of the instrument. The VSAB is administered to all residents admitted to the facility.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 1-6 and 5-8 address this standard and provide multiple internal ways a resident may report, including how he can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to the aforementioned incidents. Residents may report allegations of sexual abuse or sexual harassment by telephone and the Florida Department of Juvenile Justice hotline and the hotline of the Victim Services Center of Central Florida as determined through resident and staff interviews and the observed information posted in the facility.

Direct care staff reported that they may also use the abuse hotline to privately report sexual abuse and sexual harassment of residents. Other ways a staff member may privately report allegations of sexual abuse of residents revealed through the interviews included talking to their supervisor directly or talking to the Program Director/PREA Compliance Manager.

Additional internal ways a resident may report that was determined through resident and staff interviews and observations include: completing a grievance form; talk to any staff member; complete a form requesting to speak to a specific staff member; and complete a sick call form. Third-parties may also report allegations through the abuse hotline. The Florida Department of Juvenile Justice's website provides access for a third-party report to be made. Access to writing tools is provided for residents so that they are able to complete the forms.

Information about reporting allegtions of sexual abuse and sexual harassment is also contained in the Youth Handbook and the Client/Parent Handbook. Resident and staff interviews revealed their awareness of the methods a resident may report allegations. The facility reports that residents are not detained in the facility for civil immigration purposes.

Staff members are aware of the existence of policy regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymously, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility and they could report if they were being sexually abused to

that person if needed. The residents were aware that third-party reports could be made and that reports could be made anonymously.

The policies and staff interviews support that staff members are required to immediately document all verbal reports. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, staff meetings, employee handbook; and posted information.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Emergency grievances are addressed in Policy 4-4 and the Youth Handbook regarding sexual abuse or sexual harassment including that they may be completed and submitted at any time and may be placed in the locked grievance box. The resident is not required to handle an emergency grievance informally by attempting to resolve the situation with staff. During this audit period, there has not been a grievance submitted alleging sexual abuse. When a grievance is received regarding sexual abuse or sexual harassment, the information is immediately provided to the Program Director or the Administrator. The policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policy.

The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse or sexual harassment. The content of the grievance is reported and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or local law enforcement when the allegation is criminal in nature. The purpose of the submission of a PREA related grievance provides residents and staff another avenue for ensuring the reporting of allegations and provides management staff with the opportunity to protect the resident. A response is provided to the resident within 48 hours, informing the resident of receipt of the grievance and how it will be referred.

Policies 1-6 and 5-8 provide staff with the required information for reporting sexual abuse and sexual harassment of residents. The policies provide that a resident may be disciplined when it has been determined that a report alleging sexual abuse has been made in bad faith. Residents understand that they will not be punished if a report is made in good faith, as determined through the interviews.

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

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 4-7 and 5-8 address the residents' access to outside confidential support services. The facility has a Memorandum of Understanding (MOU) with the Victim Service Center of Central Florida for the provision of and accompaniment during forensic examinations, follow-up meetimgs, and other advocacy services. Contact information for the Victim Service Center is posted in the facility and is contained in the Youth Handbook and Client and Parent Handbook. The MOU lists the responsibilities of the Victim Service Center as well as the responsibilities of facility staff. During the comprehensive tour of the facility, the posted information and grievance and sick call boxes were observed.

The interview with the Program Director; review of the MOU and policies; and posted information support that advocacy services have been put in place. However, residents were not familiar with the specific services that would be provided by the Victim Service Center if they ever needed them. A corrective action was implemented and all residents have received a PREA education refresher session and subsequently more specific information will be covered in the regular PREA education sessions.

The interviews with staff and residents and observations during the comprehensive tour of the facility support that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents/legal guardian. All residents were aware of how they could communicate with their parents/legal guardian and that attorneys and court workers could visit the facility. Residents also confirmed that they had someone on the outside to report allegations of sexual abuse to if needed; residents were aware of all of the visitation and telephone days.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 addresses third-party reporting and interviews revealed that residents and staff are aware of the meaning of third-party reporting of sexual abuse or sexual harassment and that it can be done. All residents interviewed stated that they knew someone who did not work at the facility that they could report to regarding allegations of sexual abuse. Information regarding reporting is provided through observed postings that are located in areas of the facility that are accessible to visitors, residents and staff members. The Florida Department of Juvenile Justice website contains information regarding third-party reporting of allegations of sexual abuse.

Interviews with direct care revealed that they are aware of their obligation to receive and submit reported allegations from others. They also expressed that the ways they may report privately is through the website; hotline; and tell their supervisor or PREA Compliance Manager/Program Director; or Administrator. Staff members are also aware that they are to document all verbal reports. The residents shared the methods within the facility in which they may make third-party reports such as the grievance system, talking to staff, and utilizing the abuse reporting hotline or making a "PREA call."

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 5-8 and FDJJ 1919 address the standard and provide that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws. The staff interviewed were aware of reporting allegations and incidents according to the mandatory reporting laws and the applicable facility and Florida Department of Juvenile Justice policies. Staff members are instructed to immediately report all allegations to their immediate supervisor and the supervisors are to ensure the direct report to the Central Communications Center (CCC). Staff members are prohibited from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions.

The CCC will make appropriate notification to senior DJJ management who will make notification to management overseeing the facility where the alleged abuse occurred. Policies require the notification of the alleged victim's parents or legal guardian and to the courts. If the resident is under Department of Children and Families (DCF) custody, to the DCF Case Worker. The interview with the Program Director reflected the information provided by the policies regarding reporting allegations of sexual abuse.

Interviews with direct care, mental health and medical staff revealed that they are aware of the requirements regarding their reporting duties and understand that they are mandated reporters and must immediately report all allegations or suspicions of sexual abuse and complete a written follow-up report.

The direct care staff members interviewed and the Program Director provided that the expectation is that verbal reports are documented immediately. The facility staff members are knowledgeable of the policies' requirement to report allegations of sexual abuse that were made anonymously or by a third-party. According to interviews with the Clinical Director and Nurse, the residents are informed at the initiation of services of the limitations of confidentiality and their duty to report. .

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 10-8 address this standard and require staff to protect the residents by immediately implementing protective measures. The summarized interviews of the direct care staff and the Program Director revealed that protective measures include but are not limited to alerting supervisor and other staff; separating the the alleged victim from the alleged perpetrator by changing wings or mods; moving resident to a front room in the mod; and move resident to a room closer to the staff duty station.

The Program Director indicated that the expectation is that actions to protect a resident would be implemented immediately. Residents indicated that during the intake process, their concern about their own safety is part of the inquiries by staff and are periodically explored by treatment staff. The facility reports that during this audit period, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 provides that the Administrator/designee, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The Florida Department of Juvenile Justice Central Communications Center must also be notified to report the incident for an investigation.

The facility reports that during this audit period, there has not been a report about an incident of abuse occurring while the resident was confined in another facility. It was determined that the Program Director and the Administrator are aware of the policies and their required duties regarding reporting to other confinement facilities and the requirement that allegations received from other facilities must be investigated.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 5-8 and FDJJ 1919 require that any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. The Policy directs the first responder to request that the alleged victim does not wash; brush their teeth; change clothes; wash or do anything that may destroy evidence.

Interviews with staff members who would serve as first responders and a non-security staff revealed that they are aware of their duties. The policies instruct non-security staff who may act as a first responder to request that physical evidence be preserved and to contact direct care staff for assistance. There has not been an incident or allegation of sexual abuse or sexual harassment.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has the coordinated plan incorporated in Policy 5-8. The section outlines the actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staff. The coordinated response to an incident of sexual abuse is also aligned with policy FDJJ 1919. Staff members interviewed were familiar with their role regarding the response to an allegation or 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)

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

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

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 provides information to staff regarding the protection of residents and staff from retaliation if they should report an allegation or participate with an investigation. The Program Director serves in the role of the retaliation monitor. The interview with him in this role revealed that although there have been no allegations, he understands the responsibility of observing for whether or not retaliation occurs and identified factors that would be considered in such determination. The Program Director indicated that he would initiate periodic status checks with the resident as well as the staff member that may be involved in the situation. Policy 5-8 requires that the retaliation monitoring lasts for at least 30 days and longer if indicated, as supported by the interview.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. Segregated housing is not used at this facility for residents who allege or would have suffered 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)

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

Policies 1-6 and FDJJ 1919 and staff interviews detail the responsibility of the facility staff and provide that administrative investigations are conducted by the Florida Department of Juvenile Justice Office of the Inspector General and criminal investigations are conducted by local law enforcement. Sustained allegations as a result of a criminal investigation will be referred for prosecution. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse.

The interviews with staffs revealed there knowledge of the policies and the expectation that they are to cooperate with investigations. The FDJJ 1919 policy also provides that an investigation is not terminated because the source recants the allegation. The Office of Inspector General follows training and agency protocols in conducting administrative investigations in FDJJ settings. There have been no allegations of sexual abuse or sexual harassment reported during this audit period.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The policy and practice of the Florida Department of Juvenile Justice Office of Inspector General, 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)

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

Policy 5-8 addresses this standard and provides that the victim is to be informed when the investigation is completed and of the outcome of the investigation. Additionally, the policy provides that following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been indicted, charged, or convicted. The Program Director is familiar with these procedures and will remain abreast of the progress of an investigation by serving as the primary contact person with the investigative entities.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 and the Employee Manual address disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment policies. The facility reports that during this audit period, no staff member violated facility or agency policy regarding sexual abuse or sexual harassment. According to Policy 5-8 and the interview with the Program Director, termination is the presumptive disciplinary action regarding sexual abuse.

The policy and the interview with the Program Director support that terminations or resignations by staff that would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. During this audit period, no staff member has been disciplined for violation of sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 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 and to relevant licensing bodies.

According to the interview with a contractor, the PREA training is presented clearly and ensures the understanding of the information provided. The zero-tolerance policy and how to report allegations of sexual abuse or sexual harassment of residents is included. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 5-8 and FDJJ 1919 and the program handbook address this standard including the requirement of an administrative process for dealing with resident-on-resident sexual abuse. The staff interviews support that the formal process holds the residents accountable for their actions. Based on the allegations and the outcome of an investigation, a resident may receive loss of privileges and/or level suspension for an identified length of time; charges may be filed; resident may be placed in detention and/or another placement, according to the interview with the Program Director, handbook and policies.

Sexual activity between residents is prohibited and court or administrative processes and sanctions occur after determination that the sexual activity was coerced which was supported by the interview with the Program Director. Residents would be disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact. Isolation is not used in this facility.

The policies provide that anyone reporting in good faith will not be punished and the residents stated that they were informed of such during the admission process. Interviews with Clinical Director and the Nurse support that in addition for the victim, counseling or other interventions will be offered to address and correct the underlying reasons or motivations for abuse when the offending resident remains in or returns to the facility after an incident.

Any type interventions or treatment services provided will not be as a condition for the resident to access participation in the behavior management system, education services, or other programs. During this audit period, there have been no allegations of sexual abuse or sexual harassment.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 addresses this standard. The Referral Form is used to provide residents with a follow-up meeting with a mental health or medical practitioner when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Residents may also be referred to mental health or medical staff regarding the score on the Vulnerability to Victimization & Sexually Aggressive Behavior screening instrument and the MAYSI-2 scoring summary.

Documents and interviews revealed that residents, in general, are promptly attended to by treatment staff. 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 identified staff, based on their need to know.

A review of a sample of files indicate that medical and mental health staff members maintain documentation of the services they provide to the residents. The Nurse and the Clinical Director discussed their knowledge of informed consent and a copy of the Informed Consent form was provided for review. The consent form will be used for residents 18 years and older prior to the staff reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. No information is to be shared with other staff unless it is required for security and management decisions regarding sexual abuse history.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 and the Memorandum of Understanding between the facility and the Victim Services Center of Central Florida address this standard. Emergency medical care and crisis intervention services will be provided by medical and mental health staff as required regarding an incident of sexual abuse and at no cost to the victim.

Processes and services are in place for a victim to receive timely access to forensic medical examinations by a Sexual Assault Nurse Examiner and to sexually transmitted infections prophylaxis, where medically appropriate. Observations and interviews supported that medical and mental health staff members maintain secondary materials that document services to residents. The interviews also reflected that staff are knowledgeable of what must occur in an incident of sexual abuse.

The interviews with the Nurse and the Clinical Director revealed that residents have access to unimpeded access to emergency services and that medical and mental health services are determined according to their professional judgment. Policies and procedures and the coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding incidents and/or allegations of sexual abuse, including contacting medical and mental health staffs. The direct care staff interviewed articulated methods to implement for protecting residents who may be at risk for sexual abuse.

It was determined through the interviews with staff and residents; review of the coordinated response plan and other documentation; and observations of current practices that immediate medical treatment and crisis intervention services will be provided regarding an incident or allegation of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8, observations of current practices, and interviews with the Nurse and Clinical Director confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. Staff interviews supported that on-going services would include follow-up medical and mental health services and referrals as needed. The Nurse confirmed that resident victims will be offered tests for sexually transmitted infections as medically appropriate. The written agreement with the victim advocacy agency also provides for referral services. All treatment services will be provided at no cost to the victim.

Observations, interviews with the Nurse and the Clinical Director; and document review; revealed that medical and mental health services are consistent with the community level of care. Policies 5-8 and FDJJ 1919 and staff interviews support that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or a juvenile facility. The policy provides for a mental health practitioner to conduct a mental health evaluation within 30 days on a resident who discloses youth-on-youth abuse. The Clinical Director is familiar with the existence of the policies as they relate to ongoing care.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 5-8 provides for an incident review to be conducted within 30 days of the completion of an investigation and in accordance with the standard. The policy outlines the requirements of the standard for the areas to be assessed by the incident review team and identifies the participants. A form was reviewed that will be used to document the incident review team meetings. The form includes for the review of the considerations during the review process that are outlined in the standard and provides for corrective actions. The Program Director is familiar with the role of the incident review team.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

FDJJ 1919 and a review of agency reports confirm that the Florida Department of Juvenile Justice (FDJJ) collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for FDJJ facilities and contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ).

Florida DJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with the FDJJ directives. The FDJJ aggregates the sexual abuse data which culminates into an annual report. 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)

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

FDJJ 1919 provides guidance regarding this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. 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. The report reflects that that the agency has compared the results of annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. The annual report has been reviewed and the report is accessible to the public through the FDJJ 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)

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

FDJJ 1919 provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless statutes require otherwise. According to the 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

I certify that:

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

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

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

Shirley L. Turner — August 16, 2017

Auditor Signature — Date