PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 23, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: June 26, 2017			
Facility Information			
Facility name: Les Peters Academy			
Facility physical address: 3930 W. Dr. M. L. King, Jr. Blvd., Tampa, FL 33614			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 813-871-7655			
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: Torris Bennett			
Number of staff assigned to the facility in the last 12 months: 40			
Designed facility capacity: 24			
Current population of facility: 24			
Facility security levels/inmate custody levels: Non-Secure			
Age range of the population: 15-18			
Name of PREA Compliance Manager: John Long		**Title:** Assistant Facility Administrator	
Email address: John.Long@us.g4s.com		**Telephone number:** 813-871-7655	
Agency Information			
Name of agency: G4S Youth Services			
Governing authority or parent agency: *(if applicable)*			
Physical address: 6302 Benjamin Road, #400, Tampa, FL 33634			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-514-6275			
Agency Chief Executive Officer			
Name: Martin Favis		**Title:** Chief Executive Officer	
Email address: Martin.Favis@us.g4s.com		**Telephone number:** 419-213-6778	
Agency-Wide PREA Coordinator			
Name: Bobbi Pohlman		**Title:** PREA Coordinator	
Email address: bobbi.pohlman@us.g4s.com		**Telephone number:** 954-818-5131	

AUDIT FINDINGS

NARRATIVE

The Les Peters Youth Academy is located in Tampa, Florida and provides residential treatment services to adolescent male offenders through a contract between the Florida Department of Juvenile Justice and G4S Youth Services. The facility's capacity is 24; the same number housed in the facility on the day of the audit. The facility offers a variety of program services including:
*individual, group and family therapy sessions;
*social and independent living skills;
*medical services;
*mental health services;
*substance abuse services;
*education and vocational services;
*recreation activities; and,
*social and spiritual activities

The age range of the population is 15-18 and the average length of stay is six to nine months. The Les Peters Academy serves juvenile offenders who do not require a secure placement. The mission statement for the facility is "to successfully reintegrate Les Peters Academy youth back into the community by providing quality services, facilitating personal growth, and motivating positive change through ownership of behavior and utilization of restorative justice concepts." The residents may complete sanctions at the facility that have been assigned by the court; staff may assist residents as needed. The court sanctions may include: community service hours; apology letters/essays; and planning for the completion of restitution upon the resident's discharge from the facility. Court sanctions are identified at intake and are incorporated in the resident's performance plan. Restorative justice activities are facilitated with residents and include but are not limited to individual sessions and group meetings. These activities provide residents with the opportunity to look closely at the offenses they committed and how victims have been hurt.

The Lead Nurse coordinates the medical services and also provides medical services along with a Registered Nurse that provides evening coverage and another that provides weekend coverage. A physician visits the facility weekly and is on-call to the facility 24/7. Forensic medical examinations will be conducted at the Crisis Center of Tampa Bay or the St. Joseph Hospital in Tampa. Mental health services are provided by the Clinical Director; one full-time Therapist; one therapist as needed; and a psychiatrist who visits the facility weekly. A Case Manager collaborates with all disciplines in the planning, facilitation and coordination of services to meet the comprehensive needs of the resident. Academic and vocational services are provided based on an individualized plan developed for each resident by education staff. Direct care staff members are responsible for the general supervision of the residents and assist in creating and maintaining a positive facility culture. The comprehensive tour of the facility revealed that staff members provide direct supervision to the residents and positive interactions were observed.

The residents are provided the opportunity to participate in daily, one-hour, recreation activities and outside when weather permits. If a resident is classified as a sexual predator or otherwise, he will be placed on Security Alert or High Security Alert, at the discretion of the Facility Administrator/designee or due to the recommendation of the Treatment Team, for a period up to 30 days. The resident on this status receives increased direct supervision and monitoring. Additional criteria for placement on one of these alerts includes: history of multiple runaways or attempted escape in the last 30 days; assaulted or threatened a staff member or a resident within the last 30 days; or exhibited aggressive, violent, or destructive behaviors within the past 24 hours.

A behavior management system exists which contains four levels plus an orientation period. Incentenvies are provided as the resident progresses to the higher levels and more responsibility is required. In order for the resident to obtain a level advancement, he must meet all requirements of that level, have positive behavior in the program, and present an application to the Treatment Team. The behavior management system is based on the resident's successful completion of the identified goals in their treatment and performance plans; daily performance; compliance with scheduled activities; participation in groups; increased social skills; maintaining a positive attitude; and developing positive relationships with staff and other residents.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Les Peters Academy is located on grounds that contain five buildings. The primary building contains offices; living unit; medical clinic; large multi-purpose room; dining area; kitchen; and camera viewing room. There is an "incentive room" located near the multi-purpose room where residents may play video games, watch movies, and eat treats based on whether they have met the required behavior points to be in the room. When not in use by residents, the area may be used as a conference room. A large patio is attached to the back of the primary building. Education modules are located outside that contain classrooms and office space. There are storage and maintenance buildings outside and a building and shelter used for vocational services in automobile body repair and there is also a wood shop. Additionally, a weight room is housed in one of the smaller buildings on the grounds.

Visitors are received and required to sign in and out in the reception area/lobby of the primary building. The security camera system is located in a room at one end of the living unit and may be monitored periodically that include the various areas of the facility, inside and outside. The outside grounds contain a large basketball court and areas for residents to play football, volley ball, and participate in cookouts and other activities. There are 12 rooms on the housing unit that contain one to three beds in each and a laundry room is located on the housing unit. The muti-purpose room located outside the housing area, provides space that allows for residents to congregate in a comfortable and orderly manner.

The bathroom with showers and toilets is located in the middle of the housing unit. There are doors on the bathroom stalls and shower curtains at each shower stall. The procedures for using the bathroom are posted and support that a reasonable amount of privacy is provided for the residents to change clothes, shower and use the toilet. A sign is posted at the entrance to the housing unit instructing female staff to announce themselves when entering the housing unit. Just inside the doorway of the housing unit is another sign that serves as a reminder to female staff; it asks them if they have announced themselves.

An upgrade to the camers system has been completed since the last PREA Audit in 2014. Thirty-one new cameras exist that have either been added due to identified blind spots or to replace old cameras. Posted signs indicate where residents are allowed only with staff and areas where residents are not allowed at all. During the comprehensive tour of the facility, posters and signs were observed in various areas regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. A sick call box is located outside of the medical clinic area, accessible to all residents and a grievance box is mounted on the wall in the housing unit. The number of staff currently employed at the facility who may have contact with residents is 40 and that is the same number of staff employed at the facility since the last audit.

SUMMARY OF AUDIT FINDINGS

Prior to the site visit, a conference call was completed with the Assistant Facility Administrator who also serves as the PREA Compliance Manager and the Florida Department of Juvenile Justice (FDJJ) statewide PREA Coordinator and a FDJJ program manager. During the conference call introductions were made and the audit process was reviewed. Printed signs announcing the audit and this Auditor's contact information were posted; pictures were taken and sent to this Auditor via email. The areas were identified of where the signs were posted and they were in areas 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 Assistant Facility Administrator/PREA Compliance Manager, requesting clarification of information and additional documents. There was communication with the PREA Compliance Manager and the G4S PREA Coordinator during the document review process, as needed. The additional documentation that was requested was provided prior to the site visit and as requested during the site visit.

The site visit was conducted June 26, 2017. A comprehensive tour was conducted by the Assistant Facility Administrator and included all areas of the facility and outside grounds. Contact was made by telephone with a representative from the victim advocacy agency who verified the services of the agency to the facility as stated in the written agreement. 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. Ten residents were interviewed and ten direct care staff members were interviewed that covered all three shifts. There were 13 specialized staff interviews conducted and included a contractor and a volunteer. The interviews with staff members indicated that they had received PREA training. An exit conference was held at the conclusion of the the site visit with the Assistant Facility Administrator and a G4S Compliance Manager and a summary of the audit findings was provided.

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 facility's PREA Policy, 10-25, 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 (FDJJ) Policy 1919 serves as the overarching and comprehensive policy and Policy 10-25 is aligned with FDJJ 1919 and the PREA Standards. The PREA Policies 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. Both PREA policies contain definitions of the prohibited behaviors and addresses sanctions to be used when the PREA related policies are violated.

The Assistant Facility Administrator (AFA) serves as the PREA Compliance Manager. The AFA confirmed his role during the interview and a review of Policy 10-25 and the facility's organizational chart verified the role of the AFA as the PREA Compliance Manager. The AFA is directly supervised by the Facility Administrater and he stated during the interview that he has the time and authority required to fulfill his PREA related duties. Interviews conducted with random staff also confirmed their awareness of the role of the AFA. The PREA Compliance Manager/AFA discussed in the interview the facility's efforts in achieving compliance.

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)

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 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)

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 10-25, PREA Policy, addresses 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 during the waking hours and 1:10 during the sleeping hours. The work schedules and obsevations during the comprehensive facility tour showed the adherence to the staffing ratios and the facility policy. The staffing plan provides for the staffing ratios to be met and for a hold-over system that ensures adherence to the staffing plan. During the interviews with the AFA and the Facility Administrator, there were discussions of the considerations for the development and maintenance of the staffing plan, including the identification of blind spots and security and program needs.

The PREA Policy provide that at least once a year a review of the staffing plan occurs. The annual Staffing Plan Assessment was completed by the FDJJ statewide PREA Coordinator in conjunction with the AFA and includes but is not limted to a a review of the following: staffing plan; monitoring system; resources available and committed to ensure adnerence to the staffing plan; and the occurrence of unannounced rouonds. The form summarizing the review is signed and dated by both the AFA and the FDJJ statewide PREA Coordinator. During the comprehensive tour of the facility, observations were made of additional cameras that enhance supervision and monitoring of the residents.

The interview conducted with the AFA and a review of the the annual Staffing Plan Assessment and other documents verified that the facility complies with the current staffing plan. The PREA Policy provides for compliance to the staffing plan except during limited and exigent circumstances and that the the deviations be documented. The facility reports that the average daily number of residents during the past year is 21 and the average daily number of residents on which the current staffing plan was predicated is 21. The facility also reports that in the past 12 months there was no deviation from the staffing plan.

A review of documented unannounced rounds and the PREA Policy support that unannounced rounds are conducted by higher level and intermediate level staff and also include shift supervisors and are recorded in the log book. The unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment. A review of camera footage showed a supervisor conducting an unannounced round in various areas. The Program Director stated that his visits are unscheduled and he ensures that staffs are not alerting other staffs regarding the unannounced visits. Policy supports the practice that staff does not alert other staff when the defined PREA rounds are occurring. According to the policy, staff who alert other staff regarding the unannounced rounds will be subject to disciplinary action unless there is a legitimate reason for the announcement.

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 10-25 and 10-3 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. The interviews with direct care staff members, residents and AFA 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.

Policy 10-3 provides that a cross-gender pat-down search indicate that the second person assiting or witnessing another staff member perform a search is a female direct care staff member. During this situation, the female would not observe the resident but would observe the male staff member performing the search. The facility has begun the review of the searching of transgender and intersex residents. The

review was addressed in a staff meeting and included a presentation on working with transgender and intersex residents and conducting searches in a professional and respectful manner, consistent with security needs. The FDJJ will work in conjunction with 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 policy. Policy 10-25 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, aligned with FDJJ 1919, that guides staff regarding 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 of posted shower and bathroom procedures confirmed the practices for residents being provided reasonable privacy. The PREA Policy, 10-25, and posted signs inform staff that they must announce themselves upon entering the housing unit and another sign is posted inside the unit which reminds female staff, again, to announce their presence. According to staff and resident interviews, the opposite gender staff announce their presence verbally when entering their living areas. This practice of female staff making the anouncements was observed during the comprehensive tour of the facility and subsequently during document review.

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.

Policy 9-2 addresses securing support services for disabled residents. The facility staff has access to various resources to access interpreters and other support services, including services for the hearing impaired, intellectual disabilities, and based on the individual need of the resident. The Case Manager is responsible for securing the services needed which may include the assistance of facility staff and providing a resident a copy of the information in the dominant language other than English. Additional resources available to the facility include the American Sign Language Interpreter Services in southwest and west central Florida and Registered Court Interpreters for the Florida State Court System.

The facility has an Internal Interpreter Services List that identifies G4S staff members, their contact information and the geographic areas they are available to assist in and the languages where they may serve as an interpreter. The policy provides that residents with disabilities and who are limited English proficient be provided with the support services that would enable the identified residents to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment. 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 by FDJJ 1919. According to the staff interviewed, residents have not been used as interpreters, readers or in any way to provide interpretive services during this audit period. The resident handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also 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 3-16 and FDJJ 1919 address hiring and promotion processes and decisions. The collective Policies and interview with the Human Resources Manager provide details regarding the hiring process, completion of background checks, and the grounds for termination. The Policies are aligned with the requirements of the standard and provide that background checks occur and that child abuse registries are checked prior to employment and every five years thereafter. A review of a sample of personnel files and the interview with the Human Resources Manager confirmed the practices.

One of the pre-hire forms seeks information from applicants regarding previously related sexual misconduct allegations and convictions as observed by the Auditor and as explained by the Human Resources Manager. The policies prohibit hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor who may have contact with residents who have 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, or whether to promote an employee. The Standards of Conduct Policy, FDJJ 1800, FDJJ 1919 and the interview with the Human Resources Manager collectively provide that staff has a continuing duty to report related misconduct and provide that omissions of such conduct or providing false information will be 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)

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The camera system works in conjunction with direct staff supervision and cameras are strategically placed to assist staff in keeping residents safe from sexual abuse. There has been an upgrade to the entire camera system which includes the installation of 31 new cameras that replaced some of the existing cameras after the identification of blind spots. Additional enhancements include updated DVR that records up to 45 days. There has been no expansion or modification to the building structure since the last PREA audit in 2014.

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)

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According to Policies 10-25 and FDJJ 1919 and random staff interviews, the 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, Tampa Police Department, is responsible for conducting criminal investigations. The AFA will serve as the contact person with the Tampa Police Department regarding an investigation. 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 their local law enforcement agency.

The facility has provided for victim services through a written Prison Rape Elimination Agreement with the Crisis Center of Tampa Bay. Victim assistance that will be provided include a forensic examination conducted by a qualified medical practitioner; victim advocacy services; and access to the agency's hotline number. The Agreement also outlines the conditions of confidentiality. A telephone interview with a representative from the Crisis Center of Tampa Bay confirmed the content of the Agreement and that treatment services provided to a victim will be free of charge to the victim. There has been one allegation of sexual abuse during this audit period; it was investigated by the Tampa Police Department and a forensic examination was not necessary.

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.

The PREA Policy and FDJJ 1919 interviews with random staff and the AFA provide that allegations of sexual abuse and sexual harassment will be investigated. Administrative investigations will be conducted by OIG trained investigators and sexual abuse allegations are referred for an investigation to the Tampa Police Department and the Department of Children and Families is contacted. During the past 12 months there was an allegation of resident-on-resident sexual abuse that was referred for a criminal investigation. The case was "administratively cleared" by the Tampa Police Department and a review of the documents indicated that no further actions were required. The allegation was also reported to the appropriate FDJJ unit as required. The policies directs staff to report all allegations of sexual harassment or sexual abuse and to document the reports. The staff members are aware of the policy 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.

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 5-2 and FDJJ 1919 addresses PREA related training for staff. The policies, training materials, staff interviews, and a review of training rosters document that the staff training occurs. 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 is provided to staff, as indicated by annual training logs and acknowledgement forms; refresher training is also provided for staff where indicated. 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. Policy 5.2 provides that PREA training is conducted every two years. Staff interviews support that bi-annual training and refresher sessions are provided

All direct care staffs interviewed verified that the general topics below were included in the training:
*Facility zero-tolerance and PREA related policies;
*Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;
*Resident's right to be free from sexual abuse and sexual harassment;
*The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;
*Dynamics of sexual abuse and sexual harassment in juvenile facilities;
*Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;
*How to avoid inappropriate relationships with residents;
*Common reactions of sexual abuse and sexual harassment juvenile victims;
*Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-comforming residents;
*Mandatory reporting; and,
*Relevant laws regarding the applicable age of consent.

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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Training logs for volunteer and contractor training and the training curriculum were reviewed that documented the training. The training provided includes a review of the zeo-tolerance policy regarding sexual abuse and sexual harassment. The interview with a contractor confirmed his understanding of the facility's zero-tolerance of sexual abuse and sexual harassment. 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 regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services they provide as determined from the training materials, acknowledgement forms, and the interview with a contractor.

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

Policies 9-2 and 10-25 provide that all residents admitted receive information about the facility. PREA education is also included and involves directions to residents about how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. Policy 10-25 states that additional education be provided to residents within 10 days of intake. The Youth 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. The PREA related information is a part of the intake packet completed with each resident and residents sign an acknowledgement form. Interviews with the Case Manager and residents indicated that the PREA education sessions had occurred.

While residents were informed about the meaning of PREA and related information, their rights and how to report allegations, they were not as informed regarding the victim advocacy services that are available to them through the Crisis Center of Tampa Bay. A corrective action was implemented through the AFA. The Therapists reviewed with their individual groups, specific information regarding the advocacy services available to residents. More specific information regarding the services of the Crisis Center of Tampa Bay will be incorporated in the PREA education sessions moving forward. The refresher training for the residents was documented along with a document that outlined the information provided to residents. The PREA related information is provided to staff in policies, training and staff meetings.

The facility has the capability of providing the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the PREA related information posted in the living unit, and other areas. The facility has made prior arrangemens for the provision for interpretive and translation services and staff interviews confirmed that residents are not used as translators or readers for other residents. Facility and other G4S staffs also provide support services to residents as needed and to enure access to services that will provide disabled residents the opportunity to participate in PREA education sessions. The facility reports that 34 residents, admitted in the last 12 months, received comprehensive age-appropriate PREA education. Seven of the 10 residents interviewed, stated that they received the initial PREA information on the first day that they were admitted to the facility.

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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According to Policies 10-25 and FDJJ 1919 and staff interviews, the facility staff members do not conduct investigations. Administrative investigations are conducted by the Office of the Inspector General (OIG) and criminal investigations are conducted by the Tampa Police Department and/or the Department of Children and Families. FDJJ 1919 provide that OIG 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 Assistant Facility Administrator will remain the primary contact regarding sexual abuse investigations conducted by the Tampa Police Department and/or the Department of Children and Families.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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 FDJJ 1919 provides that medical and mental health staff members are required to receive the regular PREA training and the specialized training available online through the SkillPro training system provided by FDJJ. The mental health and medical staffs completed the general training that is provided for all staff members which is also available through the SkillPro training system. Forensic medical examinations will not be conducted by the facility medical staff. A review of the training records and interviews with medical and mental health staffs revealed their completion ofn the specialized training.

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 9-1, 9-2, 8-14, and FDJJ 1919 provide that all youth admitted to the facility are properly screened. Staff and resident interviews and a review of documentation confirmed that residents are also screened for risk of victimization and abusiveness. This vulnerability screening occurs within 24 hours of intake, whether the youth is transferred from another facility or is a 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, 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 documentation and the interview with the Clinical Director indicated that the VSAB is administered according to policy.

The facility reports that 34 residents admitted to the facility within the past 12 months received the VSAB screening. The VSAB is administered through asking questions; probing where needed; talking to parents or guardians; and reviewing related paperwork. 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 including their own concerns periodically by their Case Manager during treatment team meetings and/or by their Therapist during individual sessions. Policy 9-2 details the conditions for formal reassessments to be conducted. The information from the risk screening is accessible to the clinical staff and the files were observed to be maintained in a confidential manner. The residents interviewed were able to identify specific areas that are inquired about in the administration of 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)

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 8-14, 9-2 and FDJJ 1919 address this standard and provide guidance to staff regarding the information from the VSAB and other risk screening instruments and outline how the information is to be used. The information obtained through the administration of the screening instruments assists in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. Isolation is not used in this facility and there has not been a resident placed in isolation or controlled observation during this audit period due to concern for their safety from sexual abuse. 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 responses included separating residents; alert supervisor and other staff; provide closer supervision; and move resident to a room closer to the staff duty station.

Policy 8-14 prohibits placing lesbian, 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. Facility and agency policies and 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 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 and as confirmed through resident interviews.

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 1-5; 8-3; 10-25 and FDJJ 1919 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 FDJJ hotline and the Crisis Center of Tampa Bay may be contacted. Nine out of 10 direct care staff reported that they may also use the abuse hotline to privately report sexual abuse and sexual harassment of residents and one answer was to talk to the supervisor.

There are additional internal ways a resident may report, such as completing a grievance form; talk to any staff member; complete a form requesting to speak to a specific staff member about a minor complaint or to make a suggestion; complete a sick call form; and third parties may report allegations either in writing or the abuse hotline. 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 is posted on the living unit and other areas of the facility. 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 and residents are aware of policy and practice regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymous, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility and could report abuse to that person if needed. The residents were aware that third-party reports could be made and that reports could be made anonymously. 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, 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.

Policy FDJJ 1919 and the Youth Handbook provide that grievances regarding sexual abuse or sexual harassment 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 the past 12 months, there has not been a grievance submitted alleging sexual abuse. When a grievance is received regarding sexual abuse or sexual harassment, it is immediately provided to the Assistant Facility Administrator/designee. The policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policies.

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 FDJJ 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. There is no time limit for a resident to submit an emergency grievance alleging sexual abuse or sexual harassment and there is a response from staff within 48 hours informing the resident of receipt of the grievance and that it has been referred for investigation.

Policy 10-25 provides staff with the required information for reporting sexual abuse and sexual harassment of residents. The facility and agency 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. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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 10-25 and FDJJ 1919 address the residents' access to outside confidential support services. The facility has a written agreement with the Crisis Center of Tampa Bay for the provision of forensic examinations, follow-up meetimgs, and other advocacy services. Contact

information for the Crisis Center is posted in the facility and is contained in the Youth Handbook. The agreement lists the responsibilities of the Crisis 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 Assistant Facility Administrator; review of the written agreement and policy; 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 Crisis Center if they ever needed them. A corrective action was implemented and all residents have received a PREA education refresher session and subsequently specific information will be covered in the regular PREA education sessions. All resident interviews and the interview with the Assistant Facility Administrator and observations during the comprehensive tour 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 if they needed to. 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.

FDJJ 1919 addresss third-party reporting and interviews revealed that residents are aware that third-party reporting of sexual abuse or sexual harassment 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. Staff interviews revealed their knowledge of third-party reporting and that they can receive allegations from third parties. 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 FDJJ website contains information regarding third-party reporting of allegations of sexual abuse.

Interviews with direct care staffs 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 and tell their supervisor. Staff members are also aware that they are to document all verbal reports. Interviews with residents confirmed their knowledge of what third-party reporting means. The residents shared the methods within the facility in which residents may make third-party reports such as the grievance system, talking to staff, and utilizing the abuse reporting hotline.

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 1-5; 8-3; 10-25; and FDJJ 1919 collectively 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. Reporting according to the mandatory laws and the applicable policies was evident through document review regarding an allegation of resident-on-resident sexual abuse and the subsequent investigation conducted by the Tampa Police Department. The investigation by the Police Department was closed as "administratively cleared." The administrative review report by FDJJ concluded that there were no findings for Improper Supervison by staff.

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). 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. The CCC will make appropriate notification to senior DJJ management who will make notification to management overseeing the facility where the alleged abuse occurred. Policy 10-25 requires the Facility Administrator to notify the alleged victim's parents or legal guardians. If the resident is under Department of Children and Families (DCF) custody, the DCF Case Worker will be notified and if applicable, the attorney of record will be notified of the allegation within 14 days of receipt of the allegation, according to the Policy.

Interviews with direct care, mental health and medical staffs 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 of sexual abuse and complete a written follow-up report. All direct care staff members interviewed provided information that was aligned with the reporting requirements and that the expectation is that reports are documented immediately. The facility staff members are also required by policy to report allegations 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. The interviews with the Facility Administrator and the Assistant Facility Administrator were aligned with the facility policies and practices.

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.

The combined 10-25 and FDJJ 1919 policies require staff to protect the residents through immediately implementing protective measures. The summarized interviews of the direct care staff and the Facility Administrator revealed that protective measures include: alerting supervisor; separating the the alleged victim from the alleged perpetrator; one-on-one staff supervision; and move resident to a room closer to the staff duty station. The Facility Administrator indicated that the expectation is that actions to protect a resident would be implemented immediately. The residents are provided safety tips for self-protection while in the facility; they are included in the Youth Handbook. Residents indicated that during the intake process, their feelings about their safety are part of the inquiries by staff and are explored by staff during treatment team meetings by their Case Manager and in individual sessions with their Therapist. The facility reports that during the past 12 months, 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.

According to FDJJ 1919, 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. Policy 10-25 requires the Facility Administrator or designee to notify the facility head where the alleged incident occurred. 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. The Facility Administrator and the Assistant Facility Administrator are aware of the policy 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 10-25 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. During this audit period there was not an incident or allegation of sexual abuse that required the implementation of the first responder duties regarding preserving or maintaining evidence or the involvement of the Nurse.

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 a written institutional plan, Coordinated Response, which is an outline for the actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staffs. This coordinated response to an incident of

sexual abuse is also aligned with Policies 10-25 and FDJJ 1919. Staff members interviewed were familiar with their role regarding the response to an allegation of sexual abuse, aligned with the policies and the written Coordinated Response.

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.

Policies 10-25 and FDJJ 1919 provide protection to residents and staff from retaliation. The retaliation monitor has been identified as the Program Director. An interview revealed that he understands the responsibility of observing for whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation. The interview further revealed some of the things that would be considered in detecting retaliation, as outlined in Policy.

According to the Program Director, some of the things that have been considered to determine if retaliation exists include but is not limited to changes in a resident's housing; changes in behavior of staff and/or resident; observations of staff and resident interactions; and related reports for the staff member and resident. The document submitted indicated that status checks were made with the youth who reported an allegation. The Program Director reports and the document presented which demonstrated recording of the retaliation monitoring reveal that there has not been an incident of retaliation during the past 12 months. Policy 10-25 requires that the following be monitored to determine if retaliation is occurring: youth disciplinary reports; status checks; housing or program changes; negative performance review; or reassignment of staff.

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, including 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 10-25 and FDJJ 1919, staff interviews, and a review of documentation provide that administrative investigations are conducted by the FDJJ Office of the Inspector General and criminal investigations are conducted by the Tampa Police Department. 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. There was one alleged incident that was investigated by the Tampa Police Department which was concluded as "administratively cleared".

The policies direct facility staff to cooperate with investigations and the documentation reviewed indicates such. The FDJJ 1919 policy also provides that an investigation is not terminated because the source recants the allegation. The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings and the investigators receive training on the related Department policies. The investigative reports include descriptions and investigative facts and findings as prescribed by the standard.

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 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.

According to FDJJ 1919, the victim is to be informed when the investigation is completed and Policy 10-25 provides that the PREA Compliance Manager notifies the alleged victim of the outcome of the investigation. Documents show that the information is provided to the resident. During the past 12 months there was one allegation of sexual abuse made by a resident against another resident which was investigated by the Tampa Police Department. Written notification was made to the resident regarding the completion of the investigation and it included the identification of the investigative entity and stated the findings and explained what they meant. The Investigation Notification (PREA) form, created for the purpose of reporting the outcome of investigations to residents, also contained the signatures of the Assistant Facility Administrator/PREA Compliance Manager and the resident.

The policies provide 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 notification form provides this information to the resident. The Assistant Facility Administrator remains abreast of an investigation conducted by the Tampa Police Department by serving as the primary contact person with the Police Department.

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.

Policies 3-3 and 10-25 and the Employee Handbook provide for 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, no staff member violated facility or agency policy regarding sexual abuse or sexual harassment. 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 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. Policies provide 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. The interviews with the Human Resources Manager and the Assistant Facility Administrator revealed personnel practices and their knowledge of the related 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.

Policies 10-25 and FDJJ 1919 address 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 documentation and interviews, the facility takes measures to provide volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited and is a serious breach of conduct. An interview with a contractor and review of related documentation supported the occurrence of the PREA training and he is aware of the zero-tolerance policy and how to report allegations of sexual abuse or sexual harassment of residents.. 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.

Policy FDJJ 1919 policy addresses an administrative process for dealing with violations, including resident-on-resident sexual abuse. The policy and staff interviews support that the formal process promotes positive social change while holding the residents accountable for their actions. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Policy 10-25 provides that sexual activity between residents is prohibited and court or administrative processes and sanctions occur after determination that the sexual activity was coerced. 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.

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. 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. Any type interventions or treatment services provided are not as a condition for the resident to access participation in the behavior management system, education services, or other programs.

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.

Policies 7-3, 10-25, and FDJJ 1919 address 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 staffs and a review of documentation confirmed the practice of residents being promptly seen by treatment staff. The practice is that residents are generally seen by medical and mental health staffs on the same day of admission as part of the intake process. 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, in accordance with policy. The facility has a consent form that would be used for residents 18 years and older prior to the healthcare personnel 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.

Policies 7-30, 10.25 and FDJJ 1919; staff interviews; and a review of documented practices revealed that emergency medical care and crisis intervention services will be provided by medical and mental health staffs as required. Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate. Observations of files show that medical and mental health staff members maintain secondary materials that document services to residents and these staffs are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policies and understood by the medical and mental health staffs 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.

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 of the practitioner. Policies and procedures and a documented coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staffs. Staff interviews confirmed their awareness of the policies and the methods to implement for protecting residents. The interviews with the Nurse and the Clinical Director confirmed that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis.

The observations of the interactions and delivery of services by medical and mental health practitioners, review of records, and staff interviews indicate that unimpeded services will be available to a victim of sexual abuse. It was determined from staff interviews, review of policy, and observations that medical and mental health staff maintain secondary materials regarding medical and mental health encounters and the treatment services provide. It was determined through the interviews with medical and mental health staffs; interviews with other staff and residents; review of the written response plan and other documentation; and observations that immediate medical treatment and crisis intervention services will be provided to an alleged victim 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.

Several policies address this standard including medical policy and policies 7-13; 9-3; 9-5; 9-6; and 10-25. 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.

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 document review 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 a juvenile facility. The policy provides for a mental health practitioner to conduct a mental health evaluation within 60 days on a resident who discloses youth-on-youth abuse.

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.

Policies 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 standard. The Policies outline the requirements of the standard for the areas to be assessed by the incident review team. The Policies also identify the positions that comprise the team. The Facility Administrator and the Assistant Facility Administrator are knowledgeable of the purpose of the incident review process.

During this audit period, there was one investigation completed that met the requirement of an incident review being completed. The investigation was completed by the Tampa Police Department and was closed as "administratively cleared." The team conducted an incident review due to the term of the results of the investigation. A format has been developed for the incident review process, including allowing for the assessment of the situation and inclusion of recommendations. The Assistant Facility Administrator/PREA Compliance Manager participate as a member of the incident review team and the meeting was facilitated by the FDJJ statewide PREA Coordinator as per the policies.

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 reports 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). 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 directives by FDJJ and 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 provide 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 July 23, 2017

Auditor Signature Date