PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: September 1, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
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Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: August 7, 2017			
Facility Information			
Facility name: Melbourne Center for Personal Growth			
Facility physical address: 1000 Inspiration Lane, Melbourne, FL 32934			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 321-752-3200			
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: Cedric Cliatt			
Number of staff assigned to the facility in the last 12 months: 47			
Designed facility capacity: 32			
Current population of facility: 29			
Facility security levels/inmate custody levels: Non-Secure/Moderate			
Age range of the population: 13-18			
Name of PREA Compliance Manager: Norma Bolton		**Title:** Director of Case Management	
Email address: Spacecoast-DCM@amikids.org		**Telephone number:** 321-752-3200	
Agency Information			
Name of agency: AMIkids, Inc			
Governing authority or parent agency: *(if applicable)*			
Physical address: 5915 Benjamin Center Drive, Tampa, FL 33634			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-887-3300			
Agency Chief Executive Officer			
Name: O. B. Stander		**Title:** Chief Executive Officer	
Email address: OBstander@amikids.org		**Telephone number:** 813-887-3300	
Agency-Wide PREA Coordinator			
Name: Wendell Watson		**Title:** Regional Director	
Email address: wlw@amikids.org		**Telephone number:** 813-887-3300	

AUDIT FINDINGS

NARRATIVE

The Melbourne Center for Personal Growth is located in Melbourne, Florida and provides residential treatment services to male juvenile offenders through a contract between the Florida Department of Juvenile Justice (FDJJ) and and AMIkids, Inc. The facility's program structure is a research-based intervention model that applies a unified approach which combines education, treatment and behavior modification that provides holistic services to each resident.

The services offered at the facility are education; counseling; vocational certifications; mentoring; job placement; and follow-up services. Included in the follow-up services are ongoing communication and support to residents after they leave the program in an effort to prevent the youth from reoffending. The residents' length of stay in the facility is six to nine months.

In preparation for the facility's audit, a conference call was held with the FDJJ statewide PREA Coordinator and a program manager from the FDJJ central office. The facility staff members present for the conference call included the Executive Director and the Director of Case Management who also serves as the PREA Compliance Manager. During the conference call, introductions were made and the audit process was reviewed and discussed.

After the conference call, a printed sign announcing the site visit and the Auditor's contact information was provided to the facility. Copies of the signs were made by the PREA Compliance Manager and placed in various locations around the facility at least six weeks prior to the site visit. Pictures were taken of the postings and were sent to this Auditor via email. The locations of the signs were identified and included areas such as the administration building, school building, living unit, etc.; accessible to the residents, staff and visitors.

The PREA Pre-Audit Questionnaire, policies, and other documentation were uploaded to a flash drive and mailed to this Auditor. After an assessment of the information provided, a discussion was held with the Director of Case Management/PREA Compliance Manager, requesting clarification of information and additional information that would be available during the site visit. Additionally, this auditor made contact by phone with a representative from the victim advocacy agency who will provide services to the facility per a Letter of Agreement.

The site visit was conducted on August 7, 2017 and began with early morning interviews of direct care staff members that included two staff from the overnight shift. After these interviews, a comprehensive tour of the facility was conducted by the Director of Operations and the Director of Case Management/PREA Compliance Manager which included all areas of the facility and the outside grounds.

Observations during the facility tour revealed that staff members were providing direct supervision to the residents and the staffing ratio was being met. The printed notifications of the PREA site visit were observed to be posted in the areas previously identified with the pictures that were sent to this Auditor. There were posters and signs sighted in various locations regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. Sick call and grievance boxes and forms are maintained in the dayroom of the housing building, accessible to residents.

The interviews conducted during the site visit included 10 residents from each living unit and 10 direct care staff members from all three shifts. There were an additional 11 interviews that were conducted which included administrative, treatment and contract staff. The interviews with staff members and the residents indicated that they had received PREA training and that refresher training occurs as needed. The staff members, contractor and residents were cooperative and cordial during the interviews.

An exit conference was held at the conclusion of the the site visit with the Executive Director and and the Director of Case Management. A summary of the audit findings were provided as well as the information regarding the completion of and the timeline regarding the PREA audit written report.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Melbourne Center for Personal Growth campus includes four buildings. The administration building contains the reception and sign-in/out area; offices and cubicles; medical clinic; conference room; and a room for testing residents. There is a building that contains classrooms, dining hall and kitchen. Another building contains the two wings for the housing units and the large day room that accommodates the gathering of the residents from both wings. Each wing or housing unit is a large dormitory style room that contains bunk beds and a bathroom with showers. Residents receive a reasonable amount of privacy as they change clothes, shower and use the toilet and the shower guidelines are posted. The laundry room is located in the same building which contains the housing units. There is a smaller building that is used by residents as a work-out room and it contains weight equipment. The practice of females announcing their presence prior to entering the housing building was explained and observed during the comprehensive facility tour.

The outside grounds contain a ropes course, basketball court, and volley ball area. The grounds provide ample space for other large muscle exercises and additional recreation activities. A picturesque gazebo sits in the middle of the campus in front of the housing and the school buildings. The grounds were prettily sprinked with flowers and shrubbery. The residents play a major role in the upkeep of the grounds and in planting and maintaining the flowers and shrubs.

Forty-seven residents have been admitted to the facility in the past 12 months and forty-seven staff members have been employed at the facility in the past 12 months. All staff members may have contact with the residents. The facility provides the residents with the opportunity to participate in community service projects. Through experiential education, the facility also provides opportunities for residents to participate in life experiences that they may not have been exposed to if it was not for this program.

The Lead Nurse organizes the medical services and also provides medical services along with a part-time Nurse. A physician visits the facility weekly. Forensic medical examinations will be conducted at the local hospital. Mental health services are provided by clinicians through a contract with Circle of Care, Inc. A phychiatrist visits the facility every two weeks. Case management services are provided for each resident and include collaboration with all disciplines in the planning, facilitation and coordination of services to meet individual needs. Academic and vocational education services are provided for each resident by education staff through the Brevard County School District. Direct care staff members are responsible for the general supervision and management of the residents in all daily activities.

SUMMARY OF AUDIT FINDINGS

There have been no allegations of sexual abuse or sexual harassment during this audit period. Administrative investigations are conducted by the Florida Department of Juvenile Justice, Office of Inspector General. Allegations that are criminal in nature are investigated by local law enforcement; allegations of sexual abuse are also reported to the Florida Department of Children and Families.

The facility was found to be in compliance with all of the applicable PREA standards.

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 Florida Department of Juvenile Justice (FDJJ) has a primary PREA Policy (FDJJ 1919) that provides a guide to the facility and the facility must adhere to it regarding all PREA related policies, procedures and practices. The Melbourne Center for Personal Growth has a compilation of policies that collectively address zero-tolerance for all forms of sexual abuse and sexual harassment and provides information to staff in the prevention, detection, and responses to such allegations. The facility's series of Prison Rape Elimination Act (PREA) policies are supported by and used in conjunction with FDJJ 1919.

The facility's PREA policy numbers have a close similarity to the PREA standards' numbers. The series of PREA policies outline the strategies for addressing the components of the PREA Standards and include the service areas identified by the standards: 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.

Policy 6.11 contains definitions of the prohibited behaviors by staff and states that disciplinary measures will be implemented which are up to and including termination when PREA policies are violated by staff. The policy requires that an upper level staff member be identified as the PREA Compliance Manager. The Director of Case Management serves in the role of the PREA Compliance Manager and the policy requires that this person has sufficient time to perform the duties required for the role. The facility's organizational chart provides that the Director of Case Management is supervised by the Executive Director and through him also has contact with his supervisor, the agency's PREA Coordinator/Regional Director, as needed.

The interview with the Director of Case Management and observations by this Auditor revealed that she takes the time required and has the authority to perform the duties of the PREA Compliance Manager. Interviews conducted with random staff confirmed their awareness of the role of the Director of Case Management as the PREA Compliance Manager.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.13 addresses staffing, supervision and monitoring. The policy requires the following: adherence to the staffing plan of 1:8 during the waking hours and 1:16 during the sleeping hours; documentation of deviations from the staffing plan; annual assessment of the staffing plan; uannounced rounds; and other considerations.

Obsevations during the comprehensive facility tour indicated the adherence to the staffing ratios and the facility policy. During the interview with the Executive Director, information was provided regarding the considerations for the development and maintenance of the staffing plan, including but not limited to the program needs, make-up of the resident population; and number of supervisory staff on duty. The facility reports that the average daily number of residents is 30 and that there have not been any deviations from the required staffing.

The annual Staffing Plan Assessment form was completed by the FDJJ statewide PREA Coordinator in conjunction with the Director of Case Management and includes but is not limted to a review of staffing; resources available and committed to ensure adherence to the staffing plan; and the occurrence of unannounced rounds. The Staffing Plan Assessment indicated compliance with the staffing ratios as also supported by the interview with the Executive Director.

An interview with the Director of Case Management included her duties of conducting unannounced rounds and how she ensures that staff members do not alert other staff that the unannounced rounds are occurring as supported by policy. The documented unannounced rounds, policy, and the staff interview confirmed that the unannounced rounds are conducted. The form used to document the unannounced rounds provides for recording observations of specific practices and in identified areas. Policy supports the practice that staff does not alert other staff when the PREA unannounced rounds are occurring.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.15 prohibits cross-gender strip and visual body cavity searches at the facility. Cross-gender pat-down searches are also prohibited. The interviews with direct care staff members, residents, and Executive Director confirmed that the aforementioned types of searches are not conducted.

Staff report having received training in conducting searches of transgender and intersex residents and the training/meeting outline was reviewed as stated in policy and as confirmed through the presenter, the Director of Case Management. The direct care staff also reported their awareness of policy and through training that transtender and intersex residents cannot be searched or physically

examined just to determine the resident's genital status. According to the Director of Case Management, the facility's plan is that transgender or intersex residents will be allowed to identify the gender of the staff member they prefer to conduct the search when this situation occurs; this is also supported by policy 6.15. The Florida Department of Juvenile Justice will inform contract facilities regarding standardized practices and/or a training curriculum for the searches of transgender and intersex residents.

The policy addresses and the facility has implemented practices that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. The shower practices were explained by the Director of Operations during the comprehensive facility tour and the posted shower procedures were observed. The interviews with direct care staff and residents support that residents are provided reasonable privacy when they change clothes, use the toilet, and shower.

The policy and posted signs require the opposite gender to announce their presence when entering the housing unit and according to staff and resident interviews, this practice does occur. The practice of female staff making the anouncement was observed during the comprehensive tour of the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.16 addresses securing support services for disabled residents and not using residents as interpreters or readers. The facility staff has access to resources for interpreter services through contracting with certified professionals in the county where the facility is located, Brevard, and in the surrounding counties of Orange and Osceola. The facility maintains a list of the professionals and the contact information that may be utilized as needed. Assistance may also be continually provided by direct care, education and mental health staff. The facility currently has and has access to PREA education brochures and posters for residents in languages other than English.

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 resident assistants for the provision of PREA information for another resident. Reporting information is posted on the living units and in various areas of the facility and is available through brochures which are provided to residents and the public and in languages other than English.

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.

Policy 6.17 addresses the hiring and promotion processes and decisions. The policy and interview with the Business Manager provide details regarding the hiring process, completion of background checks, staff's continuing duty to report sexual misconduct; and the grounds for termination. The policy and general personnel policies are aligned with the requirements of the standard and provide that background checks are completed prior to employment or provision of contract services and that background checks are conducted every five years. A review of a sample of personnel files and the interview with the Business Manager confirmed the practices.

Applicants and employees are asked about previous misconduct through the completion of the personnel paperwork. The documents reviewed, staff interviews and policy 6.17 confirmed that the facility seeks information from applicants regarding previously related sexual misconduct allegations and convictions. The policy and explained personnel practices prohibit hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor or volunteer, who may have contact with residents, who has engaged in previous sexual misconduct.

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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Policy 6.18 addresses this standard and provides that consideration be provided regarding the effect of any design, acquisition, expansion or modification of physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse.

A camera system was installed in the facility in July 2017 to enhance direct supervision. The cameras have been strategically placed in consideration for blind spots and the areas where residents congregate. 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)

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 6.21 provides for the provision of victim advocacy services and random staff interviews confirmed that the facility staff members are not responsible for conducting administrative or criminal investigations. The Florida Department of Juvenile Justice (FDJJ) Office of the Inspector General is responsible for conducting administrative investigations; the Florida Department of Children and Families is responsible for conducting allegations of child abuse; and local law enforcement, Brevard County Sheriff's Office, is responsible for conducting allegations of sexual abuse that are criminal in nature.

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

The facility has Letters of Agreement for victim advocacy services with Sexual Assault Victim Services (SAVS), a department of the Women's Center; and Circles of Care, Inc. The latter agency currently provides a host of mental health services to the facility through a contract. A telephone interview with the Program Director of SAVS revealed that the services include access to the 24/7 hotline and will include upon request an assigned advocate; counseling services; referral services; and accompaniment during the forensic examination and the investigative interview. Forensic medical examinations will be conducted at the Wuesthoff Medical Center by a qualified medical practitioner. The posted reporting information and brochures were observed during the tour of the facility.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policies 6.22 and FDJJ 1919 and interviews with random staff and the Executive Director provide that allegations of sexual abuse and sexual harassment will be investigated. Administrative investigations will be conducted by the FDJJ Office of Inspector General's trained Investigators and the policies direct staff to cooperate with the investigations. Sexual abuse allegations are referred for an investigation to the Brevard County Sheriff's Office. The Department of Children and Families is also contacted regarding allegations of sexual abuse. There were no allegations reported during this audit period.

The facility's and agency's PREA policies direct staff to report all allegations of sexual abuse or sexual harassment and to document the reports. The random staff members are aware of the requirements as verified through their interviews. The FDJJ website provides the information and policy for reporting allegations of sexual abuse and reporting information is also posted in various areas of the facility, accessible to residents, staff and visitors. Information regarding reporting sexual abuse is included in the intake package sent from the facility to the resident's parent/legal guardian.

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)

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Policy 6.31 addresses PREA related training for staff. The policies, training materials, staff interviews, and a review of rosters and forms document that the staff training occurs and that the required training topics are addressed. The staff training is provided by the facility and its parent agency and through the SkillPro online training system provided by FDJJ. All staff interviewed were familiar with the PREA information regarding the primary components of preventing, detecting and responding to sexual abuse and sexual harassment of residents.

Documentation and interviews with staff and the Director of Case Management provide that refresher training is provided to staff periodically and as needed. Staff members' interviews and training records document that the staff receive PREA training as required. The facility houses males and the training considers the needs of the population served.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.32; review of documentation for training for volunteers and contractors, and an interview with two contractors confirmed that the PREA training occurs and with consideration for the services provided regarding prevention, detection and response. The training specific to volunteers and contractors also provides for the review of the the zero-tolerance policy and how to report incidents or allegations of sexual abuse and sexual harassment.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.33 addresses this standard and provides that all residents receive PREA education and that the receipt of the education be documented. The education session informs the resident of the meaning of PREA and its purpose; how to report allegations; the right to be free from retaliation; etc., in accordance with the standards. The PREA education documents were reviewed.

The Case Manager who conducts PREA education with residents also provides each resident with a brochure that contains PREA information. The Case Manager revealed that she ensures that each resident admitted to the facility receives the information as required. The residents sign an acknowledgement form indicating that they participate in a PREA education session. The resident interviews revealed that they were informed about the meaning of PREA and related information, their rights, and how to report allegations. Residents are also provided refresher training periodically as was evident during the interviews. The PREA related information is provided to staff in policies, training and staff meetings.

The facility has PREA education materials in formats accessible to all residents as determined through the interview with the Director of Case Management and a review of the various PREA brochures. The facility has the PREA related information posted in the housing and other buildings and areas. The facility maintains arrangements for the provision for interpretive and translation services through local certified providers and facility staff may also assist residents as needed. The staff interviews confirmed that residents are not used as interpreters or readers for other residents. The facility reports that 47 residents, admitted during this audit period, received age-appropriate PREA education.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 6.35 and FDJJ 1919 provide 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 the FDJJ. The mental health and medical staff completed the general PREA training that is provided for all staff members which is also available through the SkillPro training system. Training records were provided and reviewed documenting the specialized training completed by medical and mental health staff. Forensic medical examinations will not be conducted by the facility medical staff.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.41 addresses the screening for risk of victimization and abusiveness and provides that all residents be properly screened. Staff and resident interviews and a review of documentation confirmed that residents are screened for risk of victimization and abusiveness. This vulnerability screening occurs during the admissions process, whether the youth is transferred from another facility or is a new admission.

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

According to the Case Manager, pertinent information is obtained through the completion of the VSAB by asking questions of the resident and probing as needed, reading the court record, and talking to parents or guardians. The MAYSI screening instrument is also used during the admission process to identify residents who need immediate attention and futher assessment for mental health needs.

Reassessments are completed as indicated by the documentation and interviews with the Case Manager and the Director of Case Management. The information from the risk screening is accessible to the Case Manager and the Director of Case Management and the files were observed to be securely stored. The residents interviewed were able to identify specific areas that are inquired about in the administration of the VSAB and they stated that the concerns for their own safety is asked about.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policies 6.42 addresses this standard and provides information to staff on how the information obtained from the screening instrument, VSAB, be used. The collective information gleaned from the VSAB and the MAYSI assist staff in determining bed, education and other program assignments. Random staff interviews indicated that protective measures would be taken immediately if it was determined that a resident was at risk for imminent sexual abuse and the responses included separating residents; alerting supervisor; and providing closer supervision or one-on-one supervision. The facility's policy addresses the use of isolation; however, all staff interviewed revealed that the practice is that isolation is not used in this facility.

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

The Case Manager, Director of Case Management, and a mental health provider indicated through interviews that they are aware of the policy and the practices 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 the MAYSI screening instruments as confirmed through the resident interviews, interview with the Case Manager, and a review of the instruments. The VSAB and the MAYSI are administered to all residents admitted to the facility.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.51 addresses this standard and provides 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 hotline of Sexual Assault Victim Services as determined through resident and staff interviews and observations.

Additional internal ways a resident may report that were determined through resident and staff interviews and observations include: completing a grievance form; talk to any staff member; write a note and give to staff; and complete a Sick Call Request form. Third-parties may also report allegations through the abuse hotline or directly to facility staff. The FDJJ website provides access for a third-party report to be made. Access to writing tools is provided for residents so that they are able to complete the forms.

During the interviews with random staff, the responses for how staff may privately report sexual abuse or sexual harassment of residents included talking to their immediate supervisor; talking directly to the Director of Operations; or using the FDJJ abuse hotline. Staff members revealed their awareness of the existence of policy regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymously, and by third-parties.

Information about reporting allegations of sexual abuse and sexual harassment is also contained in the Parent/Student Handbook. Resident and staff interviews revealed their awareness of the methods a resident may report allegations. All residents interviewed stated that they have contact with someone who does not work at the facility and they could report if they were being sexually abused to that person if needed. The residents were aware that third-party reports could be made and that reports could be made anonymously.

The policy 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. The facility reports that residents are not detained in the facility for civil immigration purposes.

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 6.52 and FDJJ 1919 address this standard. Residents and staff reported that emergency grievances may be completed and placed in the locked grievance box in the housing building at any time and they understand that they will not be punished if a report is made in good faith. The residents will not be required to attempt to resolve an emergency grievance informally and they understand how a grievance alleging sexual abuse will be handled. Additionally, based on resident and staff interviews and the current practices within the facility, it is determined that if a grievance is received regarding sexual abuse or sexual harassment, the grievance would be responded to immediately. The policies and procedures for reporting allegations of sexual abuse or sexual harassment will be initiated and a report will be made as required.

The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the content of the grievance is reported, an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; and/or Brevard County Sheriff's Office when the allegation is criminal in nature. The purpose of the submission of an allegation of sexual abuse through the grievance system provides residents and staff another avenue for ensuring the reporting of allegations and provides staff with the opportunity to protect the resident. During this audit period, there has not been a grievance submitted alleging sexual abuse.

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 facility tour and interviews with residents and staff. The interviews revealed that residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment and that staff must report the allegation according to policy.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.53 addresses the residents' access to outside confidential support services. The facility has arrangements for victim advocacy services through a Letter of Agreement with Sexual Assault Victim Services (SAVS). The mental health services provider to the facility, Circles of Care, Inc., may also provide advocacy services as indicated by a Letter of Agreement. The facility posts the information for reporting allegations of abuse and for requesting victim advocacy services. In addition to the Letters of Agreement; interviews with the Director of Case Management, residents and SAVS representative; review of facility and FDJJ policies; and observation of posted information; it was confirmed that advocacy services have been put in place.

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

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.54 provides information to staff regarding third-party reporting. Interviews revealed that residents and staff are aware of the meaning of third-party reporting of sexual abuse or sexual harassment and the ways it could be done. Random staff interviewed revealed that they are aware of their obligation to receive and submit reported allegations from others. All residents interviewed stated that they knew someone who did not work at the facility that they could report to regarding allegations of sexual abuse.

Information regarding reporting is provided through observed postings that are located in areas of the facility that are accessible to visitors, residents and staff members. Brochures regarding how to report and other PREA related information is also provided to residents and are available to visitors, contractors and staff. The FDJJ's website contains information regarding third-party reporting of allegations of sexual abuse.

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 6.61 and FDJJ 1919 address the standard and provide that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation according to mandatory reporting laws. The staff members are prohibited from revealing any related information to anyone other than is necessary to make treatment, investigation and other security and management decisions.

The staff interviewed were aware of the procedures for reporting allegations and incidents of sexual abuse and allegations of sexual harassment according to the mandatory reporting laws and the applicable facility and FDJJ policies. Staff members are instructed to immediately report all allegations in accordance with policy. The CCC will make appropriate notification to

senior FDJJ management and the facility staff will make notification to the alleged victim's parents or legal guardian. If the resident is under the Department of Children and Families (DCF) custody, the DCF Case Worker will be notified. The interview with the Executive Director was aligned with the policies regarding reporting allegations of sexual abuse.

Interviews with direct care, mental health and medical staff revealed that they are aware of the requirements regarding their reporting duties and understand that they are mandated reporters and must immediately report all allegations or suspicions of sexual abuse and complete a written follow-up report. The Executive Director and the random staff interviewed revealed that the expectation is that verbal reports are documented immediately. The facility staff members are knowledgeable of the policies' requirement to report allegations of sexual abuse that were made directly, anonymously or by a third-party. Interviews with the Nurse and the mental health contractor provided that residents are informed at the initiation of services of the limitations of confidentiality and their duty to report.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.62 addresses this standard and require staff to protect the residents by immediately implementing protective measures. The summarized interviews of the direct care staff and the Executive Director revealed that protective measures include: closer monitoring of the resident; alerting supervisor; separating the alleged victim from the alleged perpetrator; provision of one-on-one supervision; and documenting the situation.

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

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.63 provides that the Executive Director/designee, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation to the FDJJ Central Communications Center and other investigative entities, as indicated.

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 Executive Director, Director of Operations and the Director of Case Management are aware of the policy. They understand their duties regarding reporting the sexual abuse allegations to the other confinement facility and the requirement that allegations received concerning another facility 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.

Policy 6.64 requires that any staff acting as a first responder must separate the alleged victim from the alleged abuser; 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 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. There has not been an incident or allegation of sexual abuse or sexual harassment.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.65 addresses this standard and the facility has the coordinated plan outlined in the policy. A form has also been developed, Sexual Abuse Incident Check Sheet, that itemizes the steps to take, staff to contact, and contains a section regarding retaliation monitoring. Additionally, the form outlines the actions to be taken by the various identified staff such as the first responder, supervisors, medical, mental health, and management staffs. The form allows for the staff to note when a required step has been implemented. The interviews with staff members revealed their familiarity with their individual role regarding the response to an allegation or incident of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.67 provides information to staff regarding the protection of residents and staff from retaliation if they should report an allegation or participate with an investigation. The Shift Supervisors, with the oversight of the Director of Operations, are identified by policy as monitors for retaliation; however, the Executive Director and the Director of Case Management take responsibility in assisting in the monitoring duties.

The interview with the Director of Operations revealed that he understands the responsibility of observing whether or not retaliation occurs. He identified factors that he and the Shift Supervisors will consider when monitoring for incidents of retaliation that are aligned with policy 6.67. The Director of Operations also discussed the benefits of the recently installed camera system in monitoring for the occurrence of retaliation measures against residents and staff.

If retaliation conduct is identified, the monitoring will be ongoing according to the Director of Operations. The form, PREA Retaliation Monitoring Report, has been developed and provides for the monitoring to occur for 90 days and beyond where indicated. The form identifies items that may be monitored that may assist in identifying retaliation activities.

The Director of Operations described how staff will initiate contact with residents who may have reported sexual abuse in order to get a status check on the situation. According to the interview with the Executive Director and the policy, staff members engaging in retaliation will receive disciplinary actions including and up to termination; residents engaging in such behavior will receive disciplinary work details and loss of privileges.

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. The practice of isolation is not used in this facility for residents who allege or would have suffered sexual abuse.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 6.71 and FDJJ 1919 and staff interviews detail the responsibility of the facility staff and provide that administrative investigations are conducted by the FDJJ Office of the Inspector General and criminal investigations are conducted by the Brevard County Sheriff's Office. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. Sustained allegations as a result of a criminal investigation will be referred for prosecution. The Executive Director will serve as the contact staff member for the investigative entities.

Although there have been no allegations of sexual abuse or sexual harassment, it was determined from staff interviews that they are familiar with the policies regarding reporting allegations and the subsequent investigations. It was also determined that staff understand that they are to cooperate with investigations. The FDJJ 1919 policy also provides that an investigation is not terminated because the source recants the allegation. The FDJJ Office of Inspector General's Investigators adhere to training and agency protocols for conducting administrative investigations in FDJJ settings.

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.

Policies 6.72 and FDJJ 1919 require that the facility and the FDJJ Office of Inspector General impose a standard no higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.73 addresses this standard and provides that the victim is to be informed of the outcome of an investigation of an allegation of sexual abuse. The policy provides that following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Additionally, following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been charged, indicted or convicted.

The Executive Director is familiar with this policy/procedures and will remain abreast of the progress of an investigation by serving as the primary contact person with the investigative entity. A form, Resident PREA Allegation Status Notification, has been developed to document the notification to the resident when an investigation has been conducted. The date, resident's signature and the staff's signature making the notification is required on the form. There have been no allegations of sexual abuse or sexual harassment during this audit period.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.76 states that disciplinary sanctions for staff be up to and including dismissal for those staff that violate the facility's sexual abuse and sexual harassment policies. The facility reports that during this audit period, no staff member violated facility or agency policy regarding sexual abuse or sexual harassment.

The interview with the Executive Director supports that terminations or resignations by staff that would have been terminated if not for their resignation are still reported to law enforcement if the allegation is criminal in nature and to licensing agents where indicated. During this audit period, no staff member has been disciplined for violation of sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.77 requires 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.

The interview with a contractor confirmed that the PREA training occurs and in a manner that is clearly understood. The overall strategies of zero-tolerance and how to report allegations of sexual abuse and sexual harassment of residents is included in the training. During this audit period, there have been no allegations of sexual abuse or sexual harassment involving 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 6.78 addresses this standard including the requirement of an administrative process for dealing with resident-on-resident sexual abuse. The formal process holds the residents accountable for their actions through the implementation of consequences through the behavior modification program. Based on the allegations and the outcome of an investigation, a resident may receive loss of privileges; assignment of work details; and an increase of the length of stay in the facility, according to the Executive Director. Charges may also be filed based on the outcome of the investigation and in collaboration with FDJJ. The facility does not use isolation as a disciplinary sanction.

The policy provides that any resident reporting allegations of sexual abuse in good faith will not be punished if the allegation is determined unfounded or unsubstantiated. The residents stated during the interviews that they were informed of such during the PREA education session of the admission process. Interviews with the Nurse and mental health provider and the policy support that counseling or other interventions will be offered to the victim to address and correct the underlying reasons or motivations for abuse when the offending resident remains in or returns to the facility after an incident. The resident's participation in these services will not be a condition for him to have access to programming and/or education services.

Sexual activity between residents is prohibited by policy 6.78 and such activity is considered sexual abuse if it is determined that the action was coerced. Additionally, 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. The Executive Director and the Director of Case Management/PREA Compliance Manager are familiar with the policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.81 addresses this standard and provide residents with a follow-up meeting with a mental health or medical practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Observations, review of documents and interviews revealed that residents are promptly attended to by treatment staff on a regular basis. The policy indicates that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and shall be maintained in medical and mental health files.

Medical and mental health staff members maintain documentation of the services they provide to the residents. The policy requires obtaining informed consent for residents 18 years and older prior to the staff reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. The Lead Nurse and the mental health provider interviewed, stated that they are mandated reporters.

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 6.82 and FDJJ 1919 and the Letters of Agreement for victim advocacy services address this standard. Emergency medical care and crisis intervention services will be provided by medical and mental health facility staff. Processes and services are in place for a victim to receive timely access to forensic medical examinations by a Sexual Assault Nurse Examiner or qualified practitioner at the Wuesthoff Medical Center and to sexually transmitted infections prophylaxis, where medically appropriate.

Observations and interviews supported that medical and mental health staff members maintain secondary materials that document the services they have provided to residents. The interviews and a review of the coordinated response plan revealed awareness by staff of what must occur if there is an incident of sexual abuse.

The interviews with the Lead 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 the professional judgement of the service provider. Policies and procedures and the coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding incidents and/or allegations of sexual abuse, including contacting medical and mental health staff.

The direct care staff members interviewed identified measures they could implement in efforts to keep a resident safe from a threat of imminent sexual abuse. It was determined through the interviews with staff and residents; review of the coordinated response plan and PREA policies; and observations of current practices that immediate medical treatment and crisis intervention services will be provided regarding an incident or allegation of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies 6.83 and FDJJ 1919 address this standard. It was confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. Interviews with the Lead Nurse and mental health provider interviews supported that on-going services would include follow-up medical and mental health services. The Lead Nurse confirmed that resident victims will be offered tests for sexually transmitted infections at the hospital as medically appropriate. All treatment services will be provided at no cost to the victim, as stated in policy.

The Lead Nurse, mental health provider and observations, revealed that medical and mental health services are consistent with the community level of care. The facility and agency policies and staff interviews support that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or a juvenile facility. The policy provides for an attempt for a mental health practitioner to conduct a mental health evaluation within 60 days of learning of the information on known resident-on-resident abusers. Interviews revealed a familiarity with the related policies.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 6.86 provides for an incident review to be conducted within 30 days after the completion of an investigation, unless the investigation was determined to be unfounded. The policy outlines the requirements of the standard for the areas to be assessed by the incident review team and identifies the participants. A form, Sexual Abuse Incident Report, was reviewed that will be used to document the incident review team meetings. The form includes for the review of the considerations during the review process that are outlined in the standard and provides for recommendations made by the incident review team.

The Director of Operations has been identified to be responsible for the completion of the report for the team and also must provide a copy to the Executive Director and the Director of Case Management/PREA Coordinator. The interview with the Director of Operations revealed his knowledge of the policy and his role as an incident review team member or facilitatior.

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.

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

Various types of identified data and related documents regarding sexual abuse incidents are collected by FDJJ. The facility, as a contractor, collects and maintain data in accordance with the FDJJ directives. The FDJJ aggregates the PREA related data which culminates into an annual report. The FDJJ 1919 policy requires the collection of accurate, uniform data for every allegation of sexual abuse.

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.

Policies 6.88 and FDJJ 1919 addresses this standard. The Policy states that an annual report will be prepared by FDJJ that will provide an assessment of the agency's progress in addressing sexual misconduct. The collected and aggregated data is reviewed by the FDJJ statewide PREA Coordinator to assess and improve the effectiveness of the PREA related efforts and initiatives by the State and contract facilities. An annual report is prepared that demonstrates that problems are identified and corrective actions are developed and implemented for continuous improvement and compliance.

The annual report is approved as required. The report displays and observations confirm 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 requires that data is collected and securely stored and retained for 10 years. According to the policy, the aggregated data from all facilities will be readily available to the public through the FDJJ's website, which is confirmed by a review of the posted annual reports. The review of the annual report also 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 — September 1, 2017

Auditor Signature — Date