PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Okeechobee Juvenile Offender Correction Center				
Physical Address: 5050 NE 168th Street, Okeechobee, FL 34972				
Date report submitted: April 5, 2016				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
Email: shirleyturner3199@comcast.net				
Telephone number: 678-895-2829				
Date of facility visit: March 9, 2016				
Facility Information				
Facility Mailing Address: 5050 NE 168th Street, Okeechobee, FL 34972				
Telephone Number: 863-357-9922				
The Facility is:	☐ Military	☐ County	☐ Federal	
	☒ Private for profit	☐ Municipal	☐ State	
	☐ Private not for profit			
Facility Type:	☐ Detention	☒ Corrections	☐ Other: Residential	
Name of PREA Compliance Manager: Michael Slayton, Facility Administrator			**Title:**	Facility Administrator
Email Address: Michael.Slayton@us.g4s.com			**Telephone Number:**	239-210-0940
Agency Information				
Name of Agency: G4S Youth Services				
Governing Authority or Parent Agency: NA				
Physical Address: 6302 Benjamin Road, Suite 400, Tampa, FL 33634				
Mailing Address: Same as Physical Address				
Telephone Number: 813-514-6275				
Agency Chief Executive Officer				
Name: James C. Hill, Jr.			**Title:**	President
Email Address: jim.hill@us.g4s.com			**Telephone Number:**	813-514-6275
Agency Wide PREA Coordinator				
Name: Bobbi Pohlman-Rodgers			**Title:**	Senior Director of JJDPA/PREA Compliance
Email Address: bobbi.pohlman@us.g4s.com			**Telephone Number:**	954-818-5131

AUDIT FINDINGS

NARRATIVE:

The Okeechobee Juvenile Offender Correction Center is a 96-bed facility for male juvenile offenders who have been committed to the Florida Department of Juvenile Justice (FDJJ). It is located in Okeechobee, Florida and operated by G4S Youth Services through a contract with FDJJ. The facility serves residents ranging from ages 13 to 21 who have been classified as high or maximum risk. The length of stay is from 12-18 months for residents classified as high risk and 18-36 months for those classified as maximum risk. The facility is accredited by the American Correctional Association.

Residents receive medical and mental health screenings during the intake process and on-going medical and mental health services throughout their stay in the facility. Medical services are provided by three Licensed Practical Nurses and one serves as the Health Services Coordinator, supervised by the G4S Regional Health Services Administrator. The physician visits the facility twice a week; a contract dentist is at the facility weekly and the contract optometrist visits as needed. Mental health services are provided by a Director of Clinical Services and six therapists. A consulting psychiatrist visits the facility every two weeks. Education services include courses in English, Mathematics, Science, Social Studies and Reading. Career and technical opportunities include Culinary Arts and Business Education courses. Residents also receive case management services; individual and group counseling; physical and recreational activities; and aftercare preparation.

An Individual Performance Plan is developed with goals and expectations for each resident based on his needs. Each resident is assigned a Case Manager and a Therapist prior to their arrival to the facility and meets with a Case Manager and Therapist on the first day of the intake process. The Case Managers coordinate the activities and programs the residents are involved in. The facility services include but are not limited to a cognitive-behavioral treatment approach and evidenced-based programs. A description of the program is contained in the resident handbook and each resident is provided a copy. The handbook also includes a description of the behavior management system, program rules, how to access services, and the disciplinary process. The facility has a Parents Committee and monthly conference calls are held with the Facility Administrator to discuss the needs of the facility and opportunities for improvement in identified areas. Family Day is held at the facility every quarter.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The facility has a razor wire fence around it which is monitored and cameras are strategically placed on the inside of the building and outside. The main building on the grounds includes a front entrance with a lobby, control room, and administrative offices. The area outside of the administrative offices is set up for visitation on the weekends. Beyond this area is the medical/intake area; kitchen/dining area; pill pass room; and master control. The enhanced game room is located beyond the clinic and is used as a special privilege or during inclement weather. There are six dorms with 16 rooms in each.

The dorms also have a laundry room, dayroom and classroom and the classroom contains an office for the teacher. There is also a secure unit with four cells located in the facility where residents may be placed for a short period of time in controlled observation until their behavior is under control. Controlled observation is not used as disciplinary isolation.

The Home Builders Institute has a building on the grounds that provide for classroom instruction and hands-on applications in the construction trades. The grounds contain a recreation area with a pavilion and a basketball court and a much larger recreation area where various sports are played. The cameras are primarily monitored by the Assistant Facility Administrator from the system in his office. The number of residents admitted to the facility during the past 12 months whose length of stay was more than 30 days is 41. The number of staff employed at the facility in the past 12 months who may have contact with residents is 49.

SUMMARY OF AUDIT FINDINGS:

An introductory conference call was held prior to the site visit and the audit process was discussed with facility staff and the DJJ statewide PREA Coordinator. The notifications of the on-site audit were posted in the facility prior to the site visit and pictures of the postings were forwarded to this Auditor. The Pre-Audit Questionnaire was uploaded to a flash drive with policies and supporting documentation and was received prior to the site visit. There was follow-up communication with Facility Administrator and information was clarified as needed. The Facility Administrator serves as the PREA Compliance Manager.

The site visit was conducted on March 9, 2016. Introductions were conducted with the Facility Administrator and the Assistant Facility Administrator. A comprehensive tour of the facility was provided by the Facility Administrator and the Assistant Facility Administrator. During the tour, staff members were observed to be providing direct supervision to the residents and interacting with them. Randomly selected residents and staff members who provide direct care to residents were interviewed. Direct care staff members were interviewed from all shifts. Specialized interviews were conducted which included a contract staff. During the site visit, additional documentation was provided as requested. At the conclusion of the site visit, a close-out meeting was held with the Facility Administrator and the Assistant Facility Administrator. The G4S Senior Regional Director was at the facility during the site visit.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Policy 10-25 states that the Facility Administrator or a person designated by the G4S Regional Director serves as the PREA Compliance Manager. The Facility Administrator has been designated as the PREA Compliance Manager. The interview with the Facility Administrator revealed that he has sufficient time and authority to implement and coordinate the activities regarding PREA compliance. The Facility Administrator reports to the G4S Senior Regional Director.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 and periodic internal management reviews of the staffing schedule, ensures adequate levels of staffing for all shifts. The contract with FDJJ requires staffing ratios of 1:8 during the awake hours and 1:10 during the overnight hours and the staffing documents show that sometimes there are less youth per staff. The interview with the Facility Administrator Director revealed that he reviews the staff schedule every day and explained the staff hold-over process that ensures that the ratios are maintained and that there are no deviations.

A Staffing Plan Assessment was reviewed which was completed by FDJJ's statewide PREA Coordinator. It includes a review of the items listed in the standard and other related areas of facility operations. The Staffing Plan Assessment contains a review of the staffing plan; staffing patterns; deployment of cameras; unannounced rounds; operating procedures; and other factors that contribute to maintaining compliance with the staffing plan. Policy 10-25 provides that the Administrative Duty Officer conducts unannounced rounds at least once a month and that the visits are documented in the logbook or the shift report. A review of logbook entries and an interview with the Assistant Facility Administrator confirmed that unannounced rounds occur as required. The PREA Policy and the facility practice, confirmed through the interview, prohibit staff from alerting other staff of the occurrence of the unannounced rounds.

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)

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

Policy 10-25 and resident and staff interviews provide that residents are able to shower, use the toilet, and change clothes without being viewed by female staff. Staff and residents shared that female staff members do not supervise those activities. All residents and staff interviewed confirmed that female staff members announce themselves when entering the living unit where residents may be showering, changing clothes or performing bodily functions. Policy 8-14 states that transgender or intersex residents shall not be searched or physically examined for the sole purpose of determining their genital status. Staff interviews confirmed their awareness of this Policy and report that no such searches have occurred.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.317 Hiring and Promotion Decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 3-16, Employee Recruitment and Selection, and FDJJ Policies 1800 and 1919 address this standard regarding hiring or promoting anyone who has engaged in sexual abuse in a jail, lockup or similar facility; has been convicted of engaging or attempting to engage in coerced or forced sexual activity; or has been adjudicated for any of the aforementioned activities. The Policies prohibit hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited by the standard and it provides directions regarding background checks and screenings. Any incident of sexual harassment is considered regarding the hiring or promotion of anyone. This was confirmed through the review of the hiring packet and the interview with the human resources staff.

A review of a sample of personnel files revealed that they include background checks; signed acknowledgement forms regarding PREA related issues and information received; signed disclosure forms; and interview information. The human resources staff interviewed revealed that hiring and promotion decisions are based on background information obtained and according to the considerations required by the standards. She further provided that employees are to inform management staff regarding any legal charges within 72 hours of their occurrence and that FDJJ will notify human resources if they should get an alert regarding a staff member. The policies provide that the omission of information regarding misconduct is grounds for termination of employment.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

The camera system is used to support the direct supervision provided by staff. The hard drive was recently upgraded. The Assistant Facility Administrator has the capability to monitor the cameras from his office.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

According to Policies 10-25 and FDJJ 1919 and staff interviews, the elements of the standard are met and facility staff members are not responsible for conducting administrative or criminal investigations. FDJJ 1919 and 10-25 state that the Florida Department of Juvenile Justice Office of the Inspector General (OIG) is responsible for conducting administrative investigations; the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse; and local law enforcement is responsible for conducting criminal investigations. A review of documentation shows that the facility has the FDJJ written information sheet regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011. The document is to be shared with law enforcement investigators.

The facility has provided for victim services, at no cost to the victim, through entering a Memorandum of Understanding (MOU) with a rape crisis center, Sexual Assault Program of the Treasure Coast. Assistance that will be provided by the agency include but are not limited to Sexual Assault Nursing Examiner services for a forensic examination to be conducted at the Raulerson Hospital emergency room; accompaniment during the forensic examination; referral services; and access to the 24/7 hotline number. An interview with the Director of Victim Services confirmed the content of the MOU and that advocacy services and the forensic examination will be provided to a victim when requested. There have been no forensic examinations conducted during this audit period.

Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25; FDJJ 1919; FDJJ 2020; and staff interviews support that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The Policies identify who is responsible for conducting the criminal and administrative investigations and instructs staff to cooperate with investigations. During the past 12 months there were no administrative or criminal investigations of sexual abuse and sexual harassment conducted at the facility.

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

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policies 5-1 and 5-2 address employee training and a review of the SkillPro training documents show that the training does occur. However, the staff interviews indicated that refresher training was needed. A corrective action was implemented where the Facility Administrator conducted the refresher training during a full staff meeting which was documented. The information was also shared with staff members that were unable to attend as indicated in the documentation and the Facility Administrator stated that the training was completed during the staff meeting. The facility reports that the training is tailored to the needs of the population they serve. Florida DJJ provides on-line training through the SkillPro system and facility in-house training has been recently conducted regarding specific areas of the standards.

Standard 115.332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919, a review of the training curriculum that is used for volunteers and contractors, and documented training support that volunteers and contractors receive training on their responsibilities regarding the zero-tolerance of sexual assault and sexual harassment and how to report any allegations or incidents. An interview with a contract staff, the Home Builders Institute supervisor, confirmed the contract staff's participation in PREA related training.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

According to Policy 10-25, resident and staff interviews, and a review of documentation acknowledging resident participation in PREA education sessions, all residents are provided age-appropriate PREA information during the intake process. All residents receive PREA education regardless if they are transferring from another facility or are a new admission and the facility policy addresses retaliation if a resident should report an allegation from a former facility or the current one. Staff members may assist with the PREA education for residents that are limited English proficient, visually impaired, otherwise disabled, or have limited reading skills. Additional support services may be obtained from the Registry of Certified Court Interpreters, Florida Registry of Interpreters for the Deaf, and staff members that work at other G4S facilities.

The PREA information is posted within the facility in various locations and program handbooks remain available to all residents. During her interview the Intake Coordinator explained how she reviews the PREA packet with the residents and allows them to repeat the information back to her in their own words. The packet also includes written safety tips. After the initial PREA education session, residents sign the PREA Brochure Receipt Verification form which is filed.

Standard 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses the training of the OIG Investigators, including the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Appropriate training is provided to investigative staff regarding conducting investigations in the DJJ

settings. The FDJJ information sheet regarding investigations protocols is to be shared with local law enforcement investigators by the facility management staff. The facility staff members do not conduct administrative or criminal investigations. Staff interviews confirmed the practice and they are aware of the investigative entities.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

FDJJ 1919 and facility Policies 5-1 and 5-2 address staff training. The medical and mental health staff members have received the training developed for those areas and the general training. The specialized training is developed by DJJ and is accessible to medical and mental health staffs online and is documented through the SkillPro training system. The medical and mental health staff interviewed stated that they completed the documented training. The medical staff does not conduct forensic medical examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 9-1, 8-14 and FDJJ 1919 provide information regarding screening for risk of victimization and abusiveness. Staff and resident interviews and a review of documentation confirmed that residents are screened for risk of victimization and abusiveness within 24 hours of intake, whether a transfer or new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The VSAB is used to obtain the information required by the standard.

Interviews revealed that reassessment screenings are conducted as needed on a formal basis and on an informal basis through resident meetings with treatment staff. The residents that were interviewed were able to indicate some of the questions that are contained in the VSAB. The staff member interviewed regarding the VSAB stated that she reviews the commitment packet prior to the resident's arrival, asks the resident the questions and probing as required, and she also contacts the parents/guardians for information. The documents indicate and the staff reported that a follow-up meeting with medical and mental health staffs is done immediately regarding disclosure of being a victim of sexual abuse or having perpetrated sexual abuse.

Standard 115.342 Use of Screening Information

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 9.3, 8-14 and FDJJ 1919 address this standard regarding the information from the VSAB and other risk screening instruments and provide guidance to staff on how the information is to be used to help determine housing and program assignments with the goal of keeping all residents safe. No resident has been placed in isolation during this audit period regarding their safety from sexual assault. The facility reports that isolation is not used as protective custody only as a mechanism for the resident to gain control of his behavior.

Policy 8-14 prohibit placing gay, bisexual, transgender or intersex residents in specific housing or making other assignments solely based on how they self-identify or their status and also prohibits staff from considering that identification as an indicator that these residents may be sexually abusive. Facility policy and staff interviews support that housing and program assignments for transgender or intersex residents are made on a case-by-case basis.

Standard 115.351 Resident Reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff and resident interviews revealed that they are aware of the policies regarding accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymous, and by third parties. Policies and staff interviews support that staff are

required to document verbal reports and to report the information to their supervisor who ensures the report to the Central Communications Center and other contacts. Staff receives this related information through policies and procedures, training and staff meetings

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)

FDJJ provides that a resident may submit a grievance at any time alleging sexual abuse or sexual harassment. The resident is not required to handle an emergency grievance informally by attempting to resolve the situation with staff. When a grievance alleging sexual abuse or sexual harassment is received, it is immediately provided to the Facility Administrator and the policies and procedures for reporting allegations of sexual abuse will be initiated. The grievance system does not provide for staff to investigate or resolve allegations of sexual abuse or sexual harassment. If the resident chooses, it serves as another method of reporting allegations to staff so that he may be kept safe and the allegations investigated by the proper entity.

Policy 10-25 and posted information provide staff with the required information for reporting sexual abuse and sexual harassment of residents. The agency policy provides that a resident may be disciplined when it has been determined that a report alleging sexual abuse has been made in bad faith.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 10-25 addresses this standard and requires the Facility Administrator to ensure that residents have access to an outside victim advocacy agency for emotional support services. The residents were provided an update PREA education session to review the services that will be provided by the Sexual Assault Assistance Program of the Treasure Coast, based on the information outlined in the signed MOU, including confidentiality practices. The information is also made available through posters as observed by this auditor. Services to be provided that are contained in the MOU were confirmed through a telephone interview with the Director of Victim Services. Among other services, the agency will provide residents with an advocate to be present during the forensic examination and will provide emotional support services.

According to policy and residents' interviews, the facility provides residents with reasonable and confidential access to attorneys or other legal representation and reasonable access to their parents or legal guardians. Family Day is held at the facility once a quarter.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 8-3, 10-25 and FDJJ 1919 provide that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. The report of an incident should be reported to the Central Communications Center no later than two hours after receipt of the information and to other investigative entities as appropriate. 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 notifications 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 DCF Custody, the 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.

The Senior Director of Clinical Services was filling in at the facility because the Director of Clinical Services was vacant during the time of the site visit. She indicated that the mental health staff members are aware of the requirements regarding their reporting duties and understand that they are mandated reporters. The interview with the Health Services Coordinator, management staff and direct care staff confirmed the same. The residents are informed at the initiation of services of the limitations of confidentiality and the clinical staff's 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)

Policy 10-25 instructs staff to take immediate action to keep residents safe when they learn that there is substantial risk of imminent threat of sexual abuse. Interviews with staff confirmed their knowledge of this policy and they were able to verbalize measures they would take to protect residents who are at substantial risk of imminent sexual abuse. Some of the protective measures stated that could be implemented immediately were to move the resident away from the threat by placing him in another dorm, one-on-one staff supervision, and inform the supervisor for assistance.

Information on reporting allegations are included in the resident handbook and safety tips for self-protection are reviewed during the initial PREA education session and provided to the resident. It was determined that during the past year, no resident was reported to be at substantial risk of sexual abuse. Residents indicated that during the intake process, their feelings about their safety are explored and they also report that staff will inquire about whether they feel safe in the program during treatment meetings and at other times.

Standard 115.363 Reporting to Other Confinement Facilities

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and FDJJ 1919 address this standard. The Facility Administrator, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The Facility Administrator must also notify the Central Communications Center to report the incident for

an investigation. The facility reports that during this audit period, there have not been any reports from a resident about an incident of abuse occurring while they were confined in another facility. The Facility Administrator indicated his awareness of the policy regarding reporting to other confinement facilities and the requirement that allegations received from other facilities must be investigated.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 details the first responder duties which are generally to separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Initial training had been conducted with staff; however, as a corrective action, refresher training was conducted last month (March 2016). The purpose of the refresher training was to strengthen the direct care staff's knowledge as first responders. FDJJ 1919 directs that if the employee first responder is not direct care staff, they should request that physical evidence is preserved and direct care staff should be notified. During the past 12 months, there has not been an 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)

The facility has a written institutional plan, Sexual Abuse Incident Coordinated Response Plan, which outlines the coordinated actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staff. This coordinated response to an incident of sexual abuse is also aligned with FDJJ 1919. Staff interviewed were aware of reporting; however, the purpose of the refresher training that was conducted was to strengthen the knowledge of the direct care staff.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and FDJJ 1919 and a review of reports provide that administrative investigations are conducted by the OIG and criminal investigations are conducted by the local law enforcement. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. The Policies direct facility staff to cooperate with investigations and FDJJ 1919 further provides that an investigation is not terminated because the source recants the information. The management team is familiar with these policies. The OIG follows protocols in conducting administrative investigations in FDJJ settings.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 allows for the victim to be informed that the investigation has been concluded and Policy 10-25 provides that the Facility Administrator notifies the victim or victim's parents or legal guardians. The information shared with the resident would include the results of the investigation, whether or not the alleged abuser has remained at the facility, and whether the alleged abuser has been charged or convicted of the crime. The Facility Administrator is familiar with the Policies. During the past 12 months there were investigations regarding sexual abuse conducted at the facility.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 3-3 provides that disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance policy. Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff.

During the past 12 months, no staff member has been disciplined for violation of agency sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies. Agency policy provide that terminations or resignations by staff who would have been terminated if not for the resignation, are reported to local law enforcement if the situation appeared to be criminal in nature and to relevant licensing bodies. It was determined that the human resources staff and the Facility Administrator are familiar with this information.

Standard 115.377 Corrective Action for Contractors and Volunteers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 provides guidance for this standard, including requiring any contractor or volunteer who engages in sexual abuse to be prohibited from contact with residents. The Policy also provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement agencies and to relevant licensing bodies. Policy 10-25 prohibits sexual activity between residents and volunteers and contracted personnel. Documented training participation and a review of the training guide used for volunteer and contract staffs training ensure that they have a clear understanding that a sexual relationship with a resident is strictly prohibited and is a serious breach of conduct. An interview with a contractor helped to confirm the occurrence of related training for volunteers and contractors. During this audit period, there have been no allegations of sexual assault or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 8-1 and FDJJ 1919 address the formal administrative process and the measures to be taken regarding major rule violations. This information is also addressed in the resident

handbook and isolation is not used as a sanction in response to a rule violation. However, residents who may be rarely placed in controlled observation are visited by clinical staff and are generally out within eight hours, according to staff. A resident may be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Sexual activity between residents is prohibited and administrative or court processes and sanctions occur when it has been determined that the sexual activity was coerced. Residents are disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact.

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

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)

Policies 10-25, FDJJ 1919 and 7-30 address this standard. A follow-up meeting with a medical or mental health practitioner within 14 days is required by Policy when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with medical and mental health staff confirmed the practice that residents would be seen by mental health and medical staff on the same day as they are currently as part of intake and regarding other issues.

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. Staff interviewed stated that the clinical staff and the Facility Administrator would have access to the information. The review of files revealed that medical and mental health staff members maintain documentation of the services they provide to the residents and they are mandated reporters.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 7-30 and FDJJ 1919 address this standard. Staff interviews and a review of documented practices revealed that crisis intervention services will be provided by medical and mental health staff as required. Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate.

An examination of a sample of files show that medical and mental health staff members maintain secondary materials that document services to residents and in an incident of sexual abuse the requirement of the standards will be applied as demonstrated through interviews and the current records reviewed. It is documented through policies and understood by staff that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation. The medical and mental health staffs interviewed stated that the clinical services that they provide are determined according to their professional judgment.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 10-25 and 7-30 and interviews with medical and mental health staff members confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. Policy 10-25; staff interviews; document review; and observations revealed that medical and mental health services are consistent with the community level of care. Policies, interviews and observations also support that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. 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; however, staff indicates that it would occur much sooner. There are 48 beds in the facility for residents who receive sexual offender treatment, which is integrated into their individualized treatment plan.

Standard 115.386 Sexual Abuse Incident Reviews

☐Exceeds Standard (substantially exceeds requirement of standard)

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

□Does Not Meet Standard (requires corrective action)

Policy 10-25 and FDJJ 1919 provide for an incident review to be conducted within 30 days of the completion of an investigation in accordance with the standard. During the past 12 months, there were no investigations completed regarding allegations of sexual abuse or sexual harassment. A form/format has been developed by FDJJ to use to document the proceedings and the report is to be given to the Facility Administrator who serves as the PREA Compliance Manager.

The Policies outline the requirements of the standard for discussion and review by the incident review team. The Policies also identify the positions that comprise the team. The Assistant Facility Administrator, identified as an incident review team member, is familiar with the function of the team and its purpose. According to Policy, the identified participants on the team may include the Facility Administrator; Assistant Facility Administrator; facility treatment staff; direct care staff; statewide FDJJ PREA Coordinator; FDJJ Regional Program Administrator; and other participants as needed.

Standard 115.387 Data Collection

□Exceeds Standard (substantially exceeds requirement of standard)

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

□Does Not Meet Standard (requires corrective action)

FDJJ 1919 and documentation confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for FDJJ facilities and contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ). The agency maintains and collects various types of identified data and related documents regarding sexual abuse incidents. FDJJ aggregates the sexual abuse data annually which culminates into an annual report, which has been reviewed by this Auditor. The agency provides DOJ with data as requested.

Standard 115.388 Data Review for Corrective Action

□Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses the sections of this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. The Policy also states that an annual report will be prepared that will provide an assessment of the agency's progress in addressing sexual misconduct. The annual report is approved as required. It is obvious from staff interviews, observations, and document review that the agency has compared the results of

the annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. The annual reports have been reviewed by this Auditor and the report is accessible to the public through the agency's website. There are no personal identifiers on the annual reports.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 provide that all data collected will be securely maintained and for at least 10 years after the initial collection date, unless statutes require otherwise. According to the Policy, the aggregated sexual abuse data from all facilities will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified that there are no personal identifiers, as required.

AUDITOR CERTIFICATION:

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

Shirley L. Turner

Auditor Signature

April 5, 2016

Date