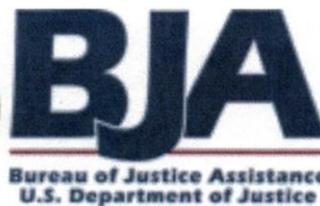


PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES



Name of Facility: Okeechobee Intensive Halfway House			
Physical Address: 7200 Highway 441 North, Okeechobee, FL 34972			
Date report submitted: April 15, 2016			
Auditor information: Shirley Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: March 21, 2016			
Facility Information			
Facility Mailing Address: 7200 Highway 441 North, Okeechobee, FL 34972			
Telephone Number: 863-763-2174			
The Facility is:	<input type="checkbox"/> Military	<input type="checkbox"/> County	<input type="checkbox"/> Federal
	<input checked="" type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
Facility Type:	<input type="checkbox"/> Detention	<input type="checkbox"/> Correction	<input checked="" type="checkbox"/> Other: Residential
Name of PREA Compliance Manager: Todd Johnson			Title: Facility Admin.
Email Address: todd.johnson@us.g4s.com			Telephone Number: 863-763-2174
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 Above			
Telephone Number: 813-514-6275			
Agency Chief Executive Officer			
Name: James C. Hill, Jr.		Title:	President
Email Address: jim.hill@us.g4s.com		Telephone:	813-514-6275
Agency Wide PREA Coordinator			
Name: Bobbi Pohlman-Rogers		Title:	Sr. Dir. JJDPA/PREA Compliance
Email Address: bobbi.pohlman@us.g4s.com		Telephone:	954-818-5131

AUDIT FINDINGS

NARRATIVE:

The Okeechobee Intensive Halfway House in Okeechobee, Florida is a 30-bed moderate risk program that houses male juvenile offenders ranging from 13-19 years old. The program is operated by G4S Youth Services through a contract with the Florida Department of Juvenile Justice (FDJJ). The Okeechobee Intensive Halfway House is a program located on a large campus made up of three distinct program units. The campus is under the leadership of the Facility Administrator and the Assistant Facility Administrator. The day-to-day operations of each program unit is under the direct management of a Program Director. Residents in each unit are provided services that include medical, mental health; education; case management; restorative justice; recreation; and social and spiritual activities. Residents have the opportunity to provide input into features of this program unit through the Resident Advisory Council that meets monthly or the community meetings which are held daily. A treatment plan of identified goals and objectives is developed for each resident based on his identified needs. The average length of stay is three to nine months.

Medical services for the campus are provided by the Health Services Administrator; eight Registered Nurses, and the physician who serves as the Designated Health Authority. Nurses are designated for each program unit. The physician visits the campus weekly and is on-call to the facility. The contract dentist is on-site weekly and a contract optometrist visits the campus on an as needed basis. Mental health and case management services are provided on campus under the guidance of the Director of Treatment Services and Therapists and Case Managers are assigned to each program unit. A series of tests are administered that helps the education staff determine the appropriate grade level for each resident. An individualized education plan, including educational goals, is developed based on the results of the tests. Physical fitness and recreational activities are designed to offer the resident a chance to learn and practice new skills and increase overall physical wellness.

Victim awareness individual sessions and group meetings are conducted with the residents where they learn about the impact of their crimes on the community, how the crimes affected the victims, and victims' rights. Any court ordered sanctions will be identified at intake and are incorporated in the resident's treatment plan. Staff members assist residents in completing court ordered sanctions which may include community service hours, apology letters or essays. Residents will not be able to pay restitution while in the facility; however, the Case Manager is available to assist the resident in planning for the payment prior to his discharge. The program contains a behavior management system known as the Behavior Motivation System consisting of three levels. It is designed to address immediate, short-term and long-term behavior and supports the development of the treatment plan. Incentives increase as the resident progresses through each level. The expectations of the resident are increased as he advances to each level of the Behavior Motivation System.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The Okeechobee Intensive Halfway House is located on a large campus with two other distinct program units. This unit consists of two primary buildings, administration and housing. The administration building contains three classrooms, including a computer lab; dining hall; offices; and conference room. The meals are delivered from the central kitchen and the dining room is also used for groups and other social activities. The housing building contains offices for two Case Managers, two Therapists and the shift supervisor. There are three dorms and each one has 10 beds and a group room. The bathroom with showers and toilets is adjacent to the living area. Residents are provided with a reasonable amount of privacy during showers, when they are changing clothes, and when using the toilet. Signs are posted on the doors where residents are not allowed to enter or where they may enter, accompanied by staff.

The outside grounds immediately surrounding the unit contain a gazebo near the administration building that may be used for counseling sessions, cooling-off, and meditation. There is also an ample area that is used for basketball, football and other games and recreational activities. Family Day activities may also be held in this area. A covered pavilion is located between the housing and administration buildings and is used for group therapy, cookouts and games. There is a large gymnasium on the grounds for the use of all three program units through coordinated schedules. The capacity for the Okeechobee Intensive Halfway House is 30 and the population during the site visit was 30. There were 85 residents admitted to the facility during the past 12 months. Forty-seven staffs were hired by the facility during the past 12 months who may have contact with residents and who are currently employed at the facility.

SUMMARY OF AUDIT FINDINGS:

An introductory telephone conference call was held prior to the site visit and the audit process was discussed with facility staff and the FDJJ statewide PREA Coordinator. The notifications of the site visit were posted in the program unit prior to the site visit and pictures of the postings were forwarded to this Auditor and the locations of the postings were identified. 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 the Program Director from one of the other units who was responsible for the data gathering for all three units in preparation for the PREA audit. Additional communication was held with this Program Director and supplementary documentation was provided and clarified as needed. The Facility Administrator is identified as the PREA Compliance Manager; however, the Assistant Facility Administrator was serving as the Acting Facility Administrator/PREA Compliance Manager during the site visit.

The site visit was conducted March 21, 2016. The on-site introductions were conducted and a comprehensive tour of the Okeechobee Intensive Halfway House was provided by its Program Director. The residents were observed to be busily preparing for the day while being directly

supervised and engaged by staff. Randomly selected residents, randomly selected direct care staff from all shifts, and specialized staff were interviewed. During the site visit, additional documentation was provided as requested. A close-out meeting was held with the Assistant Facility Administrator and the Program Director for the program unit at the conclusion of the site visit. The G4S Senior Regional Director was present on the campus during the site visit.

Number of standards exceeded: 0

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 4

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)

Auditor Comments:

Policy 10-25, The Prison Rape Elimination Act (PREA), provides guidelines for implementing the facility’s approach to complying with the requirements of the PREA standards and the zero-tolerance of all forms of sexual abuse and sexual harassment. The policy contains definitions of prohibited behaviors regarding sexual abuse and sexual harassment and sanctions for those found to have participated in prohibited behaviors. Personnel Policy 3-19 and Policy 10-25 contain prohibited behaviors for staff and includes sanctions for employees who have participated in prohibited behaviors.

The PREA Policy for the Florida Department of Juvenile Justice (FDJJ 1919) also provides guidance and strategies for PREA compliance and the facility’s PREA policies are aligned with FDJJ 1919. The Facility Administrator has been identified as the PREA Compliance Manager and is supervised by the G4S Senior Regional Director. A review of the organization chart and the interview with the Acting Facility Administrator confirmed the role. The Assistant Facility Administrator has served as the PREA Compliance Manager during the absence of the Facility Administrator.

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)
- Standard Not Applicable

Auditor Comments:

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

Standard 115.313 Supervision and Monitoring

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 10-25 requires a periodic internal review of the staffing plan to ensure adequate levels of staffing and staff interviews confirmed this practice. A review of the assigned shift documents and the use of the staff holdover system show the provision of a staffing plan of 1: 8 during the waking hours and 1:12 during the sleeping hours. Reportedly, there have not been any deviations from the standard’s ratio requirements.

A Staffing Plan Assessment was reviewed which was completed by the FDJJ statewide PREA Coordinator and includes a review of the items listed in the standard and other related areas. The Staffing Plan Assessment contains a review of the staffing plan; staffing patterns; deployment of cameras; unannounced rounds documentation; and observation of staff on duty during the completion of the assessment.

Unannounced rounds are conducted by the Assistant Facility Administrator and are documented in the logbook. A review of documentation and an interview with the Assistant Facility Administrator confirmed that unannounced rounds occur. Additionally, the shift supervisors conduct unannounced rounds during their shifts. The Administrative Duty Officer conducts safety rounds while working at the facility during their assigned weekend. The policies prohibit staff from alerting other staff of the occurrence of unannounced rounds and the Assistant Facility Administrator explained how the practices of staff discourages staff from notifying other staff 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)

Auditor Comments:

Policy 10-3 and staff and resident interviews revealed that cross-gender strip searches and cross-gender frisk searches are not conducted. Policy 10-3 addresses staff conducting searches of all residents and the different types of searches that may be conducted. The facility practice is that females do not search males; however, Policy 10-3 provides that a female staff may assist a male staff 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 assistance must be authorized by the Facility Administrator and the reason for the search documented. Interviews with residents and staff revealed that residents are able to shower, perform bodily functions, and change clothing without the opposite gender viewing them and that they are not searched by the opposite gender. Observations also supported Policy 10-25 in that residents are able to shower, use the toilet, and change clothes without being directly viewed by staff and that female staff members do not supervise those activities. All residents and staff interviewed confirmed that female staff members announce their presence when entering the individual dorms.

Staff interviews revealed that searches of intersex and transgender residents will be performed by medical staff as needed in a professional and respectful manner. The staff interviewed

indicated that they are aware of the requirement of Policy 8-14, regarding transgender or intersex residents not being searched or physically examined for the sole purpose of determining their genital status and that no such searches occurred during this audit period.

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

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 10-25 and FDJJ 1919 include that residents may not be used as interpreters 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 practice is to use bilingual staff members as interpreters and the assistance of education and mental health staff, as needed. Facility staff may use the Registry of Certified Court Interpreters as a resource and staff members from other G4S facilities to 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. The lists of interpreters are available to shift supervisors. Staff members interviewed stated that other staff at their facility would be used as interpreters or outside contacts would be made and residents are not used as interpreters for other residents. The facility has access to PREA pamphlets in other dominant languages.

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 Comments:

The facility adheres to the guidelines in Policy 3-16, Employee Recruitment and Selection, and FDJJ 1919. The policies prohibit hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited within the standard and discusses background checks and screenings. Any incident of sexual harassment is considered regarding the hiring or promotion of anyone.

A review of the policies and procedures, the interview with the Regional Human Resource Manager, and a review of a sample of personnel records revealed that the required background checks are conducted in accordance with the standard. According to the Regional Human Resources Manager, it is the employee's continuous duty to disclose any related misconduct. The policies and personnel practices provide that the omission of information regarding misconduct is grounds for termination of the employee.

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)
- Standard Not Applicable

Auditor Comments:

The facility reports that there has not been substantial expansion to the Okeechobee Intensive Halfway House and the camera system has not been updated since August 20, 2012.

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 Comments:

Policies 10-25 and FDJJ 1919 and staff interviews revealed that the facility is not responsible for conducting administrative or criminal investigations. The Office of the Inspector General conducts administrative investigations; the Department of Children and Families is responsible for conducting allegations of child abuse; and the Okeechobee County Sheriff's Office is responsible for conducting criminal investigations. The Acting Facility Administrator is familiar with the FDJJ written document that contains information regarding PREA related investigations and comprehensive uniform evidence protocols that is to be shared with investigators regarding allegations that appear to be criminal in nature.

The provision of victim advocacy services has been arranged and the services are no cost to the victim. The facility has entered into a written agreement, Memorandum of Understanding (MOU), with the Sexual Assault Assistance Program of the Treasure Coast. Services agreed to be provided are aligned with the PREA standards and include but are not limited to forensic examinations conducted by a Sexual Assault Nurse Examiner; access to a 24/7 hotline; confidential emotional support services; referral information; and follow-up directives for follow-up treatment after the resident's return to the facility. The MOU

provides that a victim advocate will accompany the victim through the forensic medical examination, conducted at the Raulerson Hospital emergency room. A telephone interview with the Victim Services Director for the State Attorney's Office and the Sexual Assault Assistance Program of the Treasure Coast confirmed the contents of the MOU and the services that will be provided at no cost to the victim. The victim advocacy agency provides the facility with posters and literature which were observed during the site visit.

A review of documentation with the G4S Regional Director revealed that there has been one allegation of sexual abuse during this audit period and it was investigated by the Okeechobee County Sheriff's Office and the FDJJ Office of Inspector General. The Sheriff's Office investigation concluded the case closed with no further action. The conclusion of the Office of Inspector General's investigation was that the allegation was unfounded.

Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 10-25 and FDJJ 1919 identify the entities that will conduct the criminal and administrative investigations and instructs the facility staff to cooperate with the investigations. During the past 12 months, there was one allegation of sexual abuse reported. The allegation was investigated by the FDJJ Office of Inspector General and the Okeechobee County Sheriff's Office. The Office of Inspector General's investigation determined that the allegation was unfounded. The Sheriff's Office closed the case with no further action. The Office of Inspector General has policies and procedures that govern administrative investigations and receive training accordingly. The FDJJ website contains the policy regarding reporting allegations of sexual abuse and sexual harassment.

Standard 115.331 Employee training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

The PREA training covers the areas referenced in the standard. Training records and staff interviews document that staff members have received the PREA training. Refresher training is provided through formal sessions and staff meetings where PREA related topics are

discussed and reviewed. Policies 5-1 and 5-2 provide guidance regarding employee training. Staff interviews and a review of the Staff Development and Training-SkillPro electronic records and training materials document the PREA training. The training is tailored to the needs of the population served. Florida DJJ provides the on-line training through the SkillPro system and G4S provides supplemental training, including updates regarding specific areas of the standards at the training site located on the same campus as the facility. Training classes were in session during the onsite audit.

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)

Auditor Comments:

Contractors and volunteers are required to receive PREA Training and FDJJ 1919, staff interview and training materials document that the PREA information is provided. A prepared document outlines information concerning PREA and the accompanying responsibilities for contractors; a training log documents the training for volunteers. The review of information with contractors and volunteers includes the zero tolerance policy and information on how to report incidents of sexual contact.

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)

Auditor Comments:

According to Policy 10-25, all residents are provided PREA information during the intake process. Staff and resident interviews and a review of documentation in residents' files confirm that residents are provided PREA education during the intake process and refresher education. Staff members in the education and treatment sections and direct care staff 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, including how to report allegations, is posted in various areas on campus and pamphlets are accessible to all residents and in the dominant languages of the population. Residents are provided a Youth Handbook that contains information concerning reporting allegations and the resident signs an Acknowledgement of Receipt form upon receiving one. The Youth Handbook also contains safety tips for the residents to use for self-protection. The tips include but are not limited to don't talk about sex to peers; don't keep secrets about sexual activity; and do not accept an offer from another person to be a "protector."

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)

Auditor Comments:

FDJJ 1919 states that staff in the Office of Inspector General will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. There is FDJJ policy that addresses training for the investigators and appropriate training is provided to investigative staff regarding conducting investigations in FDJJ settings. The facility management is aware of the information sheet, disseminated by FDJJ, identifying the expected protocols for PREA investigations that is to be shared with law enforcement investigators.

Standard 115.335 Specialized Training: Medical and Mental Health Care

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

The medical and mental health staff members have received the training developed by FDJJ for their specialized areas, as well as the initial PREA training. The training is accessible to medical and mental health staffs online and is documented through the Staff Development & Training SkillPro System. During the site visit some staff had completed the specialty training modules. A corrective action plan was implemented and has included all staff members in medical and mental health care. The training documents have been reviewed to confirm completion of the training.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

- Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9-1 and 10-25 are two of the facility policies that provide information concerning the classification and risk screening system. It is required that all residents are screened for risk of victimization and abusiveness within 24 hours of intake; however, the documented practices and the interviews confirmed that the screening occurs the day of admission. The screening is conducted on all new admissions using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). The instrument ascertains the information outlined in the standard such as prior sexual victimization or abusiveness; the youth's self-identification; current charges; offense history; and intellectual or developmental disabilities. Interviews with staff and residents and a review of the completed instruments confirmed that the VSAB is used. The resident's risk may be re-assessed periodically through sessions with treatment staff and the administration of a general risk assessment checklist.

According to the Acting Clinical Director/Therapist interviewed, prior to administering the initial VSAB, she reviews the resident's commitment file and when she meets with the resident and engages in a candid conversation about the instrument and the questions that will be asked. She added that the parents/guardians are also contacted for information related to the VSAB risk assessment screening. Additional screening and assessment tools are used to obtain information to aid staff in meeting the individual needs of the residents. The information from the VSAB risk screening instrument is accessible to the clinical staff and the files were observed to be maintained in a confidential manner. The residents interviewed were able to identify specific areas that are inquired about in the administration of the VSAB and they stated that similar questions related to safety are asked by treatment staff during treatment sessions and by other staff.

Standard 115. 342 Use of Screening Information

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies address this standard including FDJJ 1919 and 8-14. They outline that the information gleaned from the VSAB is used to help determine housing and program assignments with the goal of keeping all residents safe. It is prohibited to place gay, bisexual, transgender or intersex residents in specific housing or other assignments solely based on how they self-identify or their status. Isolation is not used in the Okeechobee Intensive Halfway House program. The Acting Clinical Director/Therapist articulated how the screening information from screening instruments, including the VSAB are used based on the identified needs of the resident.

Policy 8-14 prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy also prohibits staff from considering the identification as an indicator that these residents may be sexually abusive. The interviews conducted with staff indicated that housing and program assignments for transgender or intersex residents will be made on a case-by-case basis in accordance with the Policy.

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 Comments:

Policies 8-3, 10-25 and FDJJ 1919 details the responsibility of staff for reporting allegations of sexual abuse, including how residents and staff may privately report. The Policies provides for staffs' responsibility for ensuring residents' access to a telephone for reporting allegations through the FDJJ abuse reporting hotline. There are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation(s) that lead to abuse. A resident may complete the Let's Talk form requesting to speak to a specific staff member; complete a grievance form; complete a Sick Call Request; talk to any staff member; and third parties may report allegations to staff. The grievance and other written requests may be placed in a locked box, where it is collected by identified staff. The Youth Handbook contains information for residents on how to report sexual abuse and sexual harassment. The residents also receive contact and other information regarding services for the Sexual Assault Assistance Program of the Treasure Coast.

Observations revealed that residents are provided access to writing tools by staff in the school and in the housing areas where they are able to complete forms to report allegations of sexual abuse and sexual harassment. The various forms were observed posted and accessible to the residents. Staff and resident interviews revealed that they are aware of the policies and procedures regarding staff accepting reports of allegations of sexual abuse and sexual harassment that are made verbally, in writing, anonymous, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility that they could report abuse to if necessary. Staff members are required to document verbal reports and to report the information immediately to their supervisor and it is relayed to the Central Communications Center and the appropriate investigating entity, as verified by policy and staff interviews. The information on how to report sexual abuse or sexual harassment is provided to staff through policies and procedures, training, meetings, and postings.

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 Comments:

FDJJ 1919 and facility practice provide that grievances regarding sexual abuse or sexual harassment may be completed and submitted at any time. The facility's grievance policy does not require residents to handle a grievance informally by attempting to resolve the situation with staff. During the past 12 months, there has not been a grievance submitted alleging sexual abuse. The residents and staff identified the grievance system as one of the methods that may be used for residents to report allegations of sexual abuse and sexual harassment.

The procedure is that if a grievance is received regarding sexual abuse or sexual harassment, it is immediately provided to the Facility Administrator. The policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policy. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse or sexual harassment. The content of the grievance is reported and an investigation may be conducted by the FDJJ Office of Inspector General, Florida Department of Children and Families or the Okeechobee Sheriff's Office if the allegations are criminal in nature.

Policy 10-25 directs staff regarding reporting sexual abuse and sexual harassment of residents. The facility and agency policies provide that a resident may be disciplined when it has been determined that any report alleging sexual abuse has been made in bad faith. Residents understand that they will not be punished if a report is made in good faith. The residents interviewed revealed that they are told during the PREA education session that they will not be punished for reporting allegations of abuse.

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 Comments:

Policy 10-25 addresses this standard and ensures the Facility Administrator provides accessibility for victims to an outside victim advocacy agency for emotional support services. Victim advocacy services have been obtained with the Sexual Assault Assistance Program of the Treasure Coast and confirmed through a Memorandum of Understanding (MOU). A review of the MOU shows that the specific services to be provided are outlined and the

document contains the signatures of the Facility Administrator and the Victim Services Director. The services to be provided and the confidentiality of the services, as stated in the MOU, were confirmed through a telephone interview with the Victim Services Director. Interviews with staff and residents revealed that residents are afforded reasonable privacy regarding reporting allegations of sexual abuse. These procedures will also apply during a resident's contact to the Sexual Assault Assistance Program.

The information for reporting sexual abuse was observed on postings in the facility which included how to contact the advocacy agency for services. In addition to hotline and emotional support services, the advocacy agency will provide residents with an advocate to be present during the forensic examination and provide a Sexual Assault Nurse Examiner to conduct the examination at the Raulerson Hospital emergency room. According to policy and interviews with residents, the facility provides residents with reasonable and confidential access to attorneys and Probation Officers. A review of policy, the Youth Handbook, and other documentation and according to resident interviews, reasonable access to parents or legal guardians is also provided. The residents interviewed were aware of and could articulate the visitation days, phone call days, and Family Day activities.

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 Comments:

Third-party reporting is contained in Policy 10-25 and a Standard Operating Procedure that provides specific information for reporting allegations. Information is provided through posters that are located in areas of the facility that are accessible to staff, residents and visitors. The FDJJ website contains information for third-party reporting for the agency. Interviews with residents and staff demonstrated the awareness of both groups that allegations made by third-parties are accepted by staff and forwarded for an investigation. The residents interviewed stated that they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse who would make the report for them if necessary. Staff interviews revealed their knowledge of third-party reporting and that they can receive allegations from third-parties.

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 Comments:

Policies 8-3, 10-25 and FDJJ 1919 support the requirement that all staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. Interviews conducted with staff confirmed that they are aware of the policies regarding their reporting duties and understand that they are mandated reporters.

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. Upon being contacted regarding an allegation, the Central Communications Center will make appropriate notifications to senior FDJJ management who will then 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 the custody of the Department of Children and Families (DCF), the DCF Case Worker will be notified and if applicable, the attorney of record will be notified of the allegation within 14 days of receipt of the allegation, according to the Policy.

The interviews with management, direct care, mental health, and medical staffs revealed that they are aware of the requirements regarding their reporting duties and understand that they are mandated reporters. The interviews with the Director of Treatment Services and the Health Services Administrator and a review of documents revealed that 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)

Auditor Comments:

Policy 10-25 and FDJJ 1919 instruct staff to take immediate actions 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.

Separating residents, dorm re-assignment, and notifying supervisor would include the measures taken to protect a resident. The facility reports that during the past 12 months, the program has not determined that a resident was at substantial risk of sexual abuse. During interviews with residents, they indicated that during the intake process there was discussion about their feelings about their own safety and there safety is discussed during treatment meetings.

Standard 115.363 Reporting to Other Confinement Facilities

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 10-25 and FDJJ 1919 address this standard and identify the contacts to be made and the process for reporting. 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 the last 12 months there has not been a report about an incident of abuse occurring while the resident was confined in another facility. The Assistant Facility Administrator indicated that management staff is aware 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)

Auditor Comments:

Policy 10-25 provides the requirements for the first responder including separating the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Initial training and refresher training and updates are conducted with staff through a combination of online statewide training, in-house training, and staff meetings. 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. Interviews with staff confirmed their awareness of their responsibilities in responding to allegations of sexual abuse. During the past 12 months there was an allegation that was reported anonymously and was determined to be unfounded. There was not an incident that required the actions of a first responder.

Standard 115.365 Coordinated Response

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

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

Standard Not Applicable

Auditor Comments:

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 Comments:

Policy 10-25 directs staff to immediately report any incidents of retaliation against residents or staff members that may have reported allegations of sexual abuse. The retaliation monitor has been identified as the Assistant Facility Administrator and is charged with the responsibility of observing whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation. The interview with the Assistant Facility

Administrator indicated that he is aware and has knowledge of the duties of the retaliation monitor. During the last 12 months there was one allegation of sexual abuse which was made anonymously and was determined unfounded by the Office of Inspector General and the investigation by the Okeechobee Sheriff's Office was closed with no further action.

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)
- Standard Not Applicable

Auditor Comments:

This standard is not applicable. Segregated housing is not used in the Okeechobee Intensive Halfway House program.

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 Comments:

Policies 10-25 and FDJJ 1919 and staff interviews provide that administrative investigations are conducted by the FDJJ Office of Inspector General and criminal investigations are conducted by the Okeechobee County Sheriff's Office. The Florida Department of Children and Families is 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 allegation. The Assistant Facility Administrator, serving as the Acting Facility Administrator, is familiar with the investigative processes.

The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings and the investigators receive training on the related policies. The facility management maintains the information sheet developed by FDJJ that is to be given to the law enforcement investigator. The information provides law enforcement investigators with the expected protocols related to PREA investigations that are criminal in nature. Substantiated allegations will be referred for prosecution.

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)

Auditor Comments:

The Office of Inspector General, responsible for administrative investigations, imposes a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to Residents

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 10-25 and FDJJ-1919 allows for the victim to be informed that the investigation has been concluded. At the conclusion of an Office of Inspector General investigation, the victim or the victim's parents or legal guardian will be notified. Policy 10-25 provides that the Facility Administrator notifies the victim or victim's parents or legal guardians. This 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. There are spaces for the date of the notification, resident's signature and signature of a staff witness.

During the past 12 months there was one allegation that was information will be provided to the resident on the Investigation Notification (PREA) form. A review of the form shows that it provides for information such as the purpose of the notice; results investigated by both the Office of Inspector General and the Okeechobee County Sheriff's Office. The case was closed with no further action by the Sheriff's Office and was determined to be unfounded by the Office of Inspector General.

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 Comments:

Policy 3-3 addresses disciplinary sanctions for staff that are up to and including termination for those staff that violate the facility’s sexual abuse and sexual harassment zero-tolerance policies. Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment will be appropriate to the circumstances of the incident, staff’s disciplinary history, and the sanctions for similar cases of other staff. Agency policy provides that terminations or resignations by staff who would have been terminated if not for the resignation, are reported to local law enforcement if the situation appeared to be criminal in nature and to relevant licensing bodies. The facility reports that during this audit period no staff member has violated policy regarding sexual abuse or sexual harassment or has been reported to law enforcement for violating such policies. The Regional Human Resources Manager is knowledgeable of the personnel policies and practices and the PREA requirements in this area.

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 Comments:

Policies 3-48 and FDJJ 1919 require that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. They also provide that contractors and volunteers who engage in sexual abuse be reported to law enforcement agencies and to relevant licensing bodies. Policy 10-25 also supports this standard and prohibits sexual activity between residents and volunteers and contracted personnel. The facility ensures that volunteers and contractors have a clear understanding that sexual abuse is strictly prohibited and is a serious breach of conduct. A review of training documents and the training guide confirmed the training for volunteers and contractors. During the past 12 months, there have been no allegations of sexual assault or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary Sanctions for Residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 8-1 and FDJJ 1919 address this standard. Additionally, the Youth Handbook outlines the administrative process and the measures to be taken regarding major rule violations,

including sexual attack of peers or staff and lewd and lascivious behavior. Sexual activity between residents is prohibited and administrative or court processes and sanctions will occur when it has been determined that the sexual activity was coerced. According to the Youth

Handbook and staff, a resident may be referred to law enforcement and charged, there could be possible removal from the facility and transfer to a higher level facility based on the incident. Policy provides that 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. There have not been any findings of resident-on-resident sexual abuse during the past 12 months.

Policy 10-25 states that anyone reporting in good faith shall be immune from any civil or criminal liability. 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. It was further revealed that any type interventions or treatment services provided would not be dependent on the resident's participation in the behavior management system, education or other programs.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 7-30, 10-25 and FDJJ 1919 address this standard. It is required that a follow-up meeting with a medical or mental health practitioner occurs within 14 days when the resident discloses, during the intake screening, any prior incidents of sexual victimization or previously perpetrated sexual abuse. A review of documentation and interviews with medical and mental health staffs confirmed the practice of residents being seen by mental health and medical staff on the same day of the disclosure when made during the intake screening process. The practices of the program and the interactions of staff and residents support that residents who disclose would generally be seen the same day.

Therapists conduct group sessions everyday; individual sessions twice a month; and family sessions are conducted once a month. Policy provides that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and those staff, based on their need to know. A review of documentation revealed that the medical and mental health files are very well maintained and are inclusive of the documentation of the services provided to the residents. The medical and mental health staffs interviewed shared how the informed consent forms are used. Document review revealed that the differing forms are used regarding residents who are 18 years of age and older.

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 Comments:

Policies 7-30 and FDJJ 1919 address this standard. Staff interviews and a review of current files revealed that documentation regarding medical and crisis intervention services are maintained by medical and mental health staffs. The current review of the files and staff interviews support that appropriate documentation will also be maintained in the case of an incident or allegation of sexual abuse as required. Interviews with staff and a review of files revealed that the records would include the timelines of services and the other requirements of the standard.

Emergency services are provided at the Raulerson Hospital in Okeechobee. The documentation and observations revealed that sick call is conducted and interviews support that there is unimpeded access to emergency services. The Nurse was observed conducting pill pass and the residents had direct access to her. It is documented through policies and understood by staff that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

This standard is addressed in Policies 7-30 and 10-25. The interviews with medical and mental health staff confirmed their awareness of the policies and how the policy would be implemented regarding an incident of sexual abuse. Staff interviews and observations confirmed that medical and mental health services are consistent with the community level of care and that appropriate ongoing medical and mental health services can be provided on campus. Additionally, staff interviews indicate that services provided at the Raulerson Hospital emergency room would be used, including any provisions of services needed for

sexual abuse victims. The MOU and the interviews with the facility's Health Services Administrator and the Victim Services Director with the Sexual Assault Treatment Center of the Treasure Coast confirmed that forensic examinations will be conducted at the Raulerson Hospital emergency room. A mental health evaluation would be conducted on known resident-on-resident sexual abusers within 60 days.

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 Comments:

Policies 10-25 and FDJJ 1919 identify an incident review team to review all incidents of sexual abuse within 30 days of the conclusion of the investigation. The Policy highlights the requirements of the standard that the team should discuss and review. The Policies identify the positions that comprise the incident review team: Facility Administrator; Assistant Facility Administrator; facility treatment staffs; direct care staff; statewide FDJJ PREA Coordinator; FDJJ Regional Program Administrator; and other participants as needed. The interview with the Assistant Facility Administrator as a member of the team indicated his understanding of the policy and the purpose of the team. A form has been developed to capture the required information for documentation of an incident review team meeting. The Policies provide that the report from the incident review team be provided to the Facility Administrator, who also serves as the PREA Compliance Manager for the campus.

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 Comments:

FDJJ 1919, review of FDJJ annual PREA Incident Reports and interviews with staff confirmed the collection of incident-based, uniform and aggregated data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using an instrument with a set of definitions. The format used for FDJJ facilities and its contractors capture the

information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ).

Florida DJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. Data is collected and maintained in accordance with directives by FDJJ. Florida DJJ aggregates the sexual abuse data which culminates into an annual report. The agency provides DOJ with data as requested.

Standard 115.388 Data Review for Corrective Action

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 addresses this standard on a statewide basis and provides for an annual report to be prepared that provides an assessment of the agency's progress in addressing sexual misconduct. The FDJJ PREA Coordinator reviews the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives.

The annual report is approved as required and it is obvious from observations, and document review 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 reports have been reviewed 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)

Auditor Comments:

FDJJ-1919 provides that all data collected will be maintained for at least 10 years after the initial collection date, as well as securely stored. The report is approved and posted on the agency's website, accessible to the public, as required by the standard and confirmed through review and interview. 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 her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

Shirley L. Turner

Auditor Signature

April 15, 2016

Date