PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Okeechobee Youth Treatment Center				
Physical Address: 7200 Highway 41 North, Okeechobee, FL 34972				
Date report submitted: April 18, 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 21-22, 2016				
Facility Information				
Facility Mailing Address: 7200 Highway 41 North, Okeechobee, FL 34972				
Telephone Number: 863-763-2174				
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: Todd Johnson			**Title:**	Facility Administrator
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 Physical Address				
Telephone Number: 813-514-6275				
Agency Chief Executive Officer				
Name: James Hill			**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
Email Address: bobbi.pohlman@us.g4s.com			**Telephone Number:**	954-818-5131

AUDIT FINDINGS

NARRATIVE:

The Okeechobee Youth Treatment Center is an 80-bed facility for male juvenile offenders who have been committed to the Florida Department of Juvenile Justice (FDJJ). It is located in Okeechobee, Florida on a large campus with two other programs and is operated by G4S Youth Services through a contract with FDJJ. The facility serves residents ranging from 13 to 19 years of age who have been classified as moderate risk for placement in a residential environment. The length of stay is from three to nine months. The program provides psychotherapeutic services, cognitive skills training and relapse prevention training.

Residents receive medical and mental health services throughout their stay in the program. Medical services are provided by the Health Services Administrator and other Registered Nurses. The physician who is also the Designated Heath Authority visits the program weekly. Mental health services are under the leadership of the Director of Treatment Services and Therapists are assigned to the program. A consulting psychiatrist visits the campus weekly and there are additional contractors that provide support services. Education services, which include academic and career education, are provided through a contract with the Washington County School District. An individualized education plan is developed for residents based on their individual needs. Residents also receive case management services; individual, group and family counseling; life and social skills training; substance abuse prevention and counseling; release and transition planning; and recreation and leisure time activities.

A Needs Assessment and Performance Plan Development Meeting is held by the treatment team to determine the goals each resident will need to achieve to complete the program and these goals are incorporated in the Performance Plan. The resident and the parents or legal guardians are consulted for their input in the Performance Plan. The treatment team consists of Program Director; Case Manager; Transition Service Manager; Therapist; and Youth Care Specialist (direct care staff). The resident's assigned Case Manager is the leader of the treatment team and is the primary contact to individuals outside of the program that are involved in the resident's care such as the probation officer or counselor. The Therapists assist residents in working on personal, mental health and substance abuse issues.

Information about the program is provided to parents/guardians through direct contact, Parent Handbook, program handbook, and information letters. A behavior management system, Positive Performance System, exists where a resident may earn advancing levels through earning points for demonstrating positive behavior. Each level has identified privileges that increase with the earning of each advanced level; more responsibility is placed on the resident at each level.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There are five housing cottages that contain at least 16 residents. One of the cottages is identified as a honors cottage where placement is earned through positive behavior ant it must be maintained to remain in the honor cottage. Each cottage contains bathrooms with individual showers and toilets that

provide a reasonable amount of privacy for the residents. A recreation area, basketball court, is located outside behind each cottage. The program unit also has an administration building that contains offices and a conference room. One section of this building also contains the main medical clinic. There is a kitchen and dining room that this program's residents share with another program unit on campus. A school building is also located in the area of the Okeechobee Youth Treatment Center which contain offices and a conference area. Classrooms are adjacent to and in close proximity to the primary school building. The outside grounds contain a large open field for an array of sports and other activities.

PREA related information is posted in the cottages. One hundred thirty-three residents were admitted to the program unit during the past 12 months. The number of staff employed at the facility in the past 12 months who may have contact with residents is 57. Administrative and Disciplinary segregation are not used in this program.

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 FDJJ statewide PREA Coordinator. The notifications of the on-site audit were posted in the buildings around campus 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 the Program Director from one of the other units, responsible for the data gathering for all three units and the primary contact person for the PREA audits on the campus. 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 for the campus; 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 21-22, 2016 with the introductions and tour of the program unit occurring on the afternoon of the first day. During the tour of the program conducted by its Program Director, staff members were observed providing direct supervision to the residents. Randomly selected residents and staff members who provide direct care to residents were interviewed. Direct care staff members were interviewed from all shifts and specialized staffs were also interviewed. 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 campus' Assistant Facility Administrator and the Program Director who served as the primary contact person for the audit. The G4S Senior Regional Director whose office is on this campus was present 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, Prison Rape Elimination Act (PREA), and Policy 1919 of the Florida Department of Juvenile Justice (FDJJ 1919) provides the primary guidance to all staff regarding strategies for the application of the PREA standards. The policies are aligned and provide for PREA compliance. 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 interview with the Assistant Facility Administrator (AFA) and a review of the organizational chart revealed that the Facility Administrator (FA) manages the facility and serves as the PREA Compliance Manager. However, due to the absence of the FA, the AFA was serving as the Acting FA and PREA Compliance Manager. The interview further revealed that the position of the FA has sufficient time and authority to implement and coordinate the activities regarding PREA compliance. The FA reports directly to the 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)

Auditor Comments:

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

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Management staff conducts reviews of the staffing schedules in accordance with Policy 10-25 and utilizes the staff hold-over system to ensure adequate staffing levels. The reviewed shift reports outline staffing ratios of at least 1:8 during the waking hours and 1:12 during the sleeping hours. The staff interviews and a review of documentation state there were no deviations from the staffing plan during the last 12 months. The program unit reports that the average number of residents in the facility since August 2012 is 80 and that the average daily number of residents in which the staffing plan was predicated is 80.

The annual Staffing Plan Assessment was reviewed which was completed by FDJJ's statewide PREA Coordinator in conjunction with the Facility Administrator and includes a review of staffing levels; review of the camera monitoring system; staffing resources; review of unannounced rounds; and review of operating procedures. Documented unannounced rounds are completed by the Assistant Facility Administrator. A review of documents and staff interviews confirmed that unannounced rounds occur and are conducted by the Assistant Facility Administrator. Shift supervisors conduct unannounced rounds during their shifts and the Administrative Duty Officers conduct unannounced rounds during their assigned weekend on site. The policies and interviews support the practice that prohibits 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)

Auditor Comments:

Policy 10-3, observations, and the results of staff and resident interviews document that cross-gender pat-down searches and cross-gender strip searches are not conducted. Policy 10-3 addresses staff conducting searches of residents and provides the details of each type search and the documentation of searches. Policy 10-3 allows 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 revealed that training is provided regarding searches of residents and that they are done in s respectful manner. Staff report that searches of transgender and intersex residents will be performed by medical staff and in a professional and respectful manner as are all searches. 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 no such searches occurred during this audit period.

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 and that female staff members do not supervise the aforementioned activities. All residents and staff interviewed

confirmed that female staff follow the prompting of the observed posted signs and announce themselves when entering the cottages where residents may be showering, changing clothes or performing bodily functions. It was observed that there were curtains and that residents are provided a reasonable amount of privacy while they are performing hygiene activities and bodily functions. The supervision of bathroom activities is supervised by same gender staff members who are strategically placed during showers and use of the toilet.

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 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 their awareness of staff members who may be used as interpreters and the existence of the list of external 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)

Auditor Comments:

G4S Policy 3-16 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 staff interview.

The Regional Human Resources Manager reports that all staff hired during this audit period received background checks and verbalized her knowledge of the hiring and promotion process requirements during the interview. In the past 12 months, there were 57 employees hired who had criminal background record checks. A review of a sample of personnel files revealed documented confirmation of background checks; signed acknowledgement forms regarding PREA related issues and information received; signed disclosure forms; interview information; and five-year required re-screened background checks where indicated.

The staff interview also revealed that hiring and promotion decisions are based on background information obtained and according to the considerations required by the standards. The policies provide that the omission of information regarding misconduct is grounds for termination of employment. Employees have a continuing affirmative duty to disclose any PREA related misconduct.

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)

Auditor Comments:

This standard is not applicable. There has not been a substantial expansion to the program buildings and there have been no updates to the camera system 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:

According to Policies 10-25 and FDJJ 1919 and staff interviews, facility staff members are not responsible for conducting administrative or criminal investigations. FDJJ 1919 and 10-25 provide that the Florida Department of Juvenile Justice Office of the Inspector General is responsible for conducting administrative investigations; the Florida Department of Children

and Families is responsible for conducting allegations of child abuse; and local law enforcement is responsible for conducting criminal investigations. Facility management has the FDJJ written information sheet regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011. The information is to be shared with investigators from the Okeechobee County Sheriff's Office prior to an investigation.

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 Assistance Program of the Treasure Coast. Assistance that will be provided by the agency includes Sexual Assault Nurse Examiner services; presence of a victim advocate through the forensic examination; referral services; and other support services. 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)

Auditor Comments:

Policies 10-25, FDJJ 1919 and FDJJ 2020 address allegations of sexual abuse. Staff interviews revealed that they knew the entities responsible for completing administrative and criminal investigations for 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 investigations completed regarding allegations of sexual abuse or sexual harassment.

The Florida Department of Juvenile Justice website contains the policy regarding reporting allegations of sexual abuse and sexual harassment. The Office of Inspector General follows unit specific policy in conducting administrative investigations. The facility provides parents/ guardians and visitors with information regarding how to report allegations of sexual abuse and sexual harassment. Staff interviews were in accordance with policy in that all referrals of allegations for investigations are 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)

Auditor Comments:

Policies 5-1 and 5-2 address employee training and staff interviews and a review of the Skill-Pro training documents confirmed the training as required by the standard and includes the zero-tolerance policies. Documents and staff interviews also support that PREA refresher training is provided and reviews and updates are provided during staff meetings. The training is tailored to the needs of the population served and staff members have received training as required by the standard.

A review of a sample of staff training records and staff interviews support that initial training and refresher training occurs. There is documentation of staffs' receipt of PREA training and the comprehensive PREA training materials. Florida DJJ provides on-line training through Skill-Pro and facility in-house training has been conducted regarding specific areas of the standards. The training unit is located on this campus with the three program units.

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:

A review of the training curriculum used for volunteers and contractors, training logs and signed acknowledgement statements document that PREA training occurs for volunteers and contractors. The training includes the responsibilities of contractors and volunteers regarding the zero-tolerance of sexual assault and sexual harassment and how to report any allegations or incidents. An interview with a contractor, the school Principal, confirmed the participation of the education contractors in PREA training and documentation supported the practice. A refresher and update session had already been scheduled by the Principal for the education program staff during the week of the site visit.

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:

Policy 10-25, resident and staff interviews, and a review of forms acknowledging resident participation in PREA education sessions, document that 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. The Policy addresses retaliation if a resident should report an allegation from a former facility or the current one. The residents' interviews also revealed that they had been informed about the services provided by the Sexual Assault Assistance Program of the Treasure Coast.

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. Information related to PREA is posted throughout the program unit and in the Youth Handbook.

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 addresses the training of the Office of Inspector General investigators. Investigators receive training regarding the handling of sexual misconduct incidents and reports. Appropriate training is provided to investigative staff concerning conducting investigations in the DJJ settings. The FDJJ information sheet regarding investigations protocols is disseminated to facilities for it to be shared with local law enforcement by management staff. The facility staff members do not conduct administrative or criminal investigations. Staff interviews revealed that 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)

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. The medical staff does not conduct forensic medical examinations.

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 FDJJ 1919 provide guidance to staff concerning screening residents 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 Sexuality Aggressive Behavior (VSAB). The VSAB is used to obtain the information required by the standard which include but is not limited to prior victimization or abusiveness; current charges and offense history; physical disabilities; intellectual or developmental disabilities; the resident's concern for his own safety; and age .

The facility reports that 133 residents received the screening during the last 12 months. 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 interviewed were able to indicate some of the questions that are contained on the VSAB and stated that they were asked the questions on the first day they arrived on campus.

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 9.3, 8-14 and FDJJ 1919 address this standard regarding the information obtained from the VSAB and other risk screening instruments and outline 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; isolation is not used.

Policy 8-14 prohibits placing gay, bisexual, transgender or intersex residents in specific housing or making other assignments solely based on how residents self-identify or their status. The Policy also prohibits staff from considering identification of gay, bisexual, transgender, or intersex as an indicator that the resident may be sexually abusive. Policy and staff interviews support that housing and program assignments for transgender or intersex

residents will be made on a case-by-case basis. The staffs interviewed are familiar with policies as they would relate to gay, bisexual, transgender, or intersex residents.

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 and practice 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.

Additional internal ways a resident may report include completing a grievance form; complete a Sick Call Request form; talk to any staff member; complete a Let's Talk form and request to speak to a specific staff member; and third parties may report allegations. The contact information of the Sexual Assault Assistance Program of the Treasure Coast is also provided to the residents through postings. 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 Youth Handbook.

Interviews with direct care staff and residents 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 the Central Communications Center within two hours of receipt of the verbal report. Staff receives this related information through policies and procedures, training and the Employee Handbook.

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:

Grievances alleging sexual abuse or sexual harassment may be completed at any time and placed in the locked grievance box. The resident is not required to handle a PREA related grievance informally by attempting to resolve the situation with staff. When a PREA related

grievance is received, it is immediately provided to the Facility Administrator and the policies and procedures for reporting allegations of sexual abuse are initiated and a report is made to the Central Communications Center as required by policy. The Parent Handbook informs the parent/guardian that they may file a grievance concerning staff and program actions, including rules and regulations and any condition where they feel their child's rights have been violated.

The facility's grievance system is not intended to provide for an investigation or to resolve allegations of sexual abuse. The information in the grievance is reported and an investigation will be conducted by the Office of Inspector General, Department of Children and Families and/or the Okeechobee County Sheriff's Office. The option to submit a grievance concerning sexual abuse provides residents with another avenue for reporting allegations and provides management staff with the opportunity to intervene and protect the resident. During the past 12 months, there has not been a grievance filed alleging sexual abuse. Policy 10-25 and the Employee Handbook provide staff with the 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 grievance alleging sexual abuse has been filed 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)

Auditor Comments:

Policy 10-25 requires the Facility Administrator to ensure that residents have access to an outside victim advocacy agency for emotional support services. There is documentation of a Memorandum of Understanding (MOU) between the facility and a rape crisis center, Sexual Assault Treatment Program of the Treasure Coast. The MOU contains a description of the services that will be provided to victims of sexual assault. The resident is provided with general and contact information, including confidentiality practices, during PREA education sessions and the information is also made available through observed posters. 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 ensure a forensic examination by a Sexual Assault Nurse Examiner, provide residents with an advocate to be present during the forensic examination, and will provide emotional support services.

The resident interviews confirmed that they have reasonable and confidential access to attorneys or other legal representation and reasonable access to their parents or legal guardians. Residents were able to articulate about Family Day where there are planned pleasurable activities for residents and their family members. Each resident interviewed were also familiar with visitation and phone call days.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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 have someone who does not work at the facility that they could report to regarding sexual abuse. Staff interviews revealed their knowledge of third-party reporting. The postings in various areas provide information regarding reporting allegations and is 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)

Auditor Comments:

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 and was supported through staff interviews. The direct report of an incident should be made to the Central Communications Center no later than two hours after receipt of the information. 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 Central Communications Center which receives calls for allegations of sexual abuse and sexual harassment will make the 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. Interviews further revealed that staff members are aware of the requirement regarding their reporting duties and understand that they are mandated reporters. Clinical staff members inform residents at the initiation of services of their duty to report and the limitations of their confidentiality based on interviews and a review of a sample of files.

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 instructs staff to take immediate action to keep residents safe when they learn that there is substantial risk of an 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 maintain sight and sound supervision; notify supervisor; re-assign a resident to another cottage; and provide one-on-one staff supervision. Safety tips for self-protection while in the program unit are listed in the Youth Handbook and each resident signs a form acknowledging review and receipt of the Handbook.

During the past 12 months, it was not determined that a resident was at substantial risk of being sexually abused. 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.

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 19-25 and FDJJ 1919 address this standard and requires 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 Assistant Facility Administrator is aware of the procedures 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 provide guidance to staff regarding 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. Staff reported having received initial training, refresher sessions and updates in staff meetings. The staff training unit is located on the same grounds as the program unit. Staff interviews revealed that they are aware of the steps to take if they are the first responder. FDJJ 1919 provides that when 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, a non-direct care staff or direct care staff has not acted as 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 various identified staff such as the first responder, supervisors, medical, mental health, and management staffs. This coordinated response to an incident of sexual abuse is also aligned with FDJJ 1919. The random staff members interviewed were familiar with the role of the first responder.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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)

Auditor Comments:

Policies 10-25 and FDJJ 1919 provide protection to residents and staff from retaliation if they should report an allegation of abuse or cooperate with an investigation. The retaliation monitor has been identified as the Assistant Facility Administrator. He understands that he is charged with observing 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 with the retaliation monitor was aligned with the Policy requirements of observing resident and staff interactions and a review of Let's Talk and grievance forms. There have been no allegations of sexual abuse or sexual harassment during the past 12 months.

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

This standard is not applicable. Segregated housing or isolation is not used in this 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 document that administrative investigations are conducted by the Office of Inspector General and criminal investigations are conducted by the Okeechobee County Sheriff's Office. Additionally, the Florida Department of Children and Families are called when there is an allegation of sexual abuse.

The Policies direct facility staff to cooperate with investigations and FDJJ 1919 provides that an investigation is not terminated because the source recants the information. The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings. The campus management staff is familiar with the FDJJ information sheet regarding the expected protocols related to PREA investigations that are criminal in nature.

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:

FDJJ 1919 and staff interview provide that the Office of Inspector General, responsible for administrative investigations, impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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. This information will be provided to the resident on the Investigation Notification (PREA) form. A review of the form provides for the purpose of the notice and the results of the investigation. The form also provides for the resident's signature and signature of a staff witness. The form is designed to contain the information required in the standard such as 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. The form will also let a resident know if the findings of an investigation were Unfounded. During the past 12 months there were no administrative or criminal investigations conducted within the program unit. The campus management is aware of the process.

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 provides that disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance policies. The facility reports that during the last 12 months there were no PREA policy violations by staff. Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment would 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 Regional Human Resources Manager is knowledgeable of the personnel policies and practices.

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 address this standard, including requiring that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Policy 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. The facility ensures that volunteers and contractors have a clear understanding that sexual contact with a resident is strictly prohibited and is a serious breach of conduct.

Interviews with a contractor, review of the training curriculum used for volunteers and contractors, and review of a sample of personnel records regarding training documents 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 the formal administrative process and the measures to be

taken regarding major rule violations. This information is also addressed in the Youth Handbook and isolation is not used as a sanction in response to any rule violation. A resident may also 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. Policies 10-25 and FDJJ 1919 and interviews with mental health and medical staffs revealed 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 interventions or treatment services provided will 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 10-25 and FDJJ 1919 include providing for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with medical and mental health staffs confirmed the practice of residents being routinely seen by a mental health and medical staff member on the same day of admission screenings. A review of documentation indicates that a resident was provided follow-up on the same day as the disclosure during the screening process.

Policy supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and those staff, based on their need to know. A review of files show that medical and mental health staff members maintain documentation of the services they provide to the residents. Medical and mental health staffs' interviews revealed their knowledge of informed consent regarding 18 year olds and how it is used and the consent form was reviewed.

Standard 115.382 Access to Emergency Medical and Mental Health Services

□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)

Auditor Comments:

Policies 7-30 and FDJJ 1919 address the elements of this standard. Staff interviews and a review of documented practices revealed that crisis intervention services will be maintained by medical and mental health staff as required. Observations of files show that medical and mental health staff members maintain secondary materials that document services to residents. In an incident of sexual abuse the requirement of the standards will be met as demonstrated through interviews and the records reviewed and the processes discussed. 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 Memorandum of Understanding and the interviews with the rape crisis center representative, Health Services Administrator, Director of Treatment Services, and the Assistant Facility Administrator ensure access to emergency mental health and medical services due to an incident of sexual abuse.

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

□Exceeds Standard (substantially exceeds requirement of standard)

XMeets 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 7-30 and interviews with medical and mental health staff confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate, including the availability of testing for sexually transmitted infections. 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 ensure 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. The mental health policies, procedures and practices support that known resident-on-resident abusers will receive a mental health evaluation within the 60-day requirement period.

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 provide for an incident review to be conducted within 30 days of the completion of an investigation in accordance with this standard. During the past 12 months, there were no administrative or criminal investigations conducted within the program unit. The interview with the Assistant Facility Administrator revealed his familiarity with the process of the incident review and that the meeting process includes documented findings related to an incident of sexual abuse by identified participants, within 30 days of the completion of an investigation of allegations of sexual abuse.

The incident review report process allows for the inclusion of recommendations and the report is provided to the Facility Administrator, who also serves as the PREA Compliance Manager. The Policies outline the requirements of the standard for discussion and review by the incident review team such as consideration of any policy changes needed; examination of any motivations for the incident; consideration of physical barriers; and assessment of the staffing levels. The Policies also identify the staff positions that comprise the incident review team. The participants on the team may include the 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 incident review team member, Assistant Facility Administrator, interviewed is familiar with the purpose of the team.

Standard 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919, documentation and communication with the FDJJ statewide PREA Coordinator 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 DOJ is provided 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:

According to FDJJ 1919, 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 FDJJ statewide PREA Coordinator has confirmed the practice and the annual report is reviewed and approved as required. 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 results of staff interviews, observations, and document review reveal that the agency has compared the results of the annual reports and uses the data 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)

Auditor Comments:

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 — April 18, 2016

Auditor Signature — Date