PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Okeechobee Youth Development Center/Correctional Center				
Physical Address: 7200 Highway 41 North, Okeechobee, FL 34972				
Date report submitted: April 20, 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 22-23, 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:				
Physical Address: 6302 Benjamin Road, Suite 400, Tampa, FL 33634				
Mailing Address: Same as Physical Address				
Telephone Number: 813-514-6275				
Agency Chief Executive Officer				
Name: James C. Hill, Jr.			**Title:**	**President**
Email Address: jim.hill@us.g4s.com			**Telephone Number:**	**813-514-6275**
Agency Wide PREA Coordinator				
Name: Bobbi Pohlman-Rodgers			**Title:**	**Senior Director of JJDPA/PREA Compliance**
Email Address: bobbi.pohlman@us.g4s.com			**Telephone Number:**	**954-818-5131**

AUDIT FINDINGS

NARRATIVE:

The Okeechobee Youth Development Center (OYDC)/Correctional Center (CC) is a 50-bed program unit for male juvenile offenders who have been committed to the Florida Department of Juvenile Justice (FDJJ). The facility is located in Okeechobee, Florida and is operated by G4S Youth Services through a contract with FDJJ. The program is located on a large campus occupied by two other program units under the leadership of a Facility Administrator and an Assistant Facility Administrator. The daily operations of each program unit are managed by a Program Director. This program unit is comprised of two sections, OYDC and CC (OYDC/CC). The OYDC is a behavioral and mental health treatment program that serves residents ages 13 to 21 who are classified as high risk and the length of stay is nine to 12 months. The CC is a highly structured program for residents classified as maximum risk and serves ages 13 to 21; the length of stay is 18-36 months.

The program unit offers mental health overlay services; substance abuse prevention and counseling; case management services; life and social skills training; education/vocational services; release and transition planning; and recreation and leisure time activities. Both program unit components also provide psychotherapeutic services that include individual, group and family counseling; cognitive skills training; and relapse prevention training. Medical and mental health screenings are conducted during the intake process and on-going clinical services are provided throughout the resident's stay in the program unit.

Medical services are provided campus wide by the Health Services Administrator and other Registered Nurses. The physician who is also the Designated Heath Authority visits the campus weekly. Mental health services are under the leadership of the Director of Treatment Services. A Therapist is assigned to each resident and provides daily group therapy services as well as individual and family counseling sessions. A consulting psychiatrist visits the campus weekly and there are additional contractors that provide support services. Education services are provided through a contract with the Washington County School District. Each resident is also assigned a case manager who also serves as the primary contact person to individuals outside of the program that are involved in the resident's care.

An individualized treatment plan and goals are developed for each resident based on their identified needs. A behavior management system exists where a resident may earn advancing levels through earning points for demonstrating positive behavior. The system is designed to address immediate, short-term and long-term behavior and supports 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 system.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is maintained within additional security fencing on the campus where secured care is provided. One building serves as the housing unit with three halls; two halls contain 17 rooms and one hall contains 16 rooms. The three living units extend from a control room where there is a view of all three halls. There are two cells that are used as a temporary measure for controlled observation that provides residents with the opportunity to gain control of out of control behavior. A Therapist and a Case Manager are located on each hall. The school building is across from the living unit. Another building is the administration building where a reception area and offices are located. The dining hall building is used for meals and it also contains the general store where items may be purchased with the points earned through the behavior management system.

There is ample space for outside recreation and other activities. The yard includes a half court and full court area for basketball and a covered pavilion. The procedures and practices provide residents with a reasonable amount of privacy during showers, while using the toilet, and when changing clothes. PREA related information is posted in various areas of the program unit and policy and practice provide the residents with access to telephones for reporting allegations of sexual abuse. The designed program capacity is 50 and there were 49 residents in the facility during the site visit. The total number of residents admitted to the program unit during the past 12 months whose length of stay was for 72 hours or more is 17 for the OYDC and 54 for the CC. The number of staff employed in the program unit during the past 12 months who may have contact with residents is 52.

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 facility 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 for this program unit, who was also responsible for the data gathering for the other two PREA audits on campus. The Program Director provided additional documentation as requested and information was clarified as needed.
The Facility Administrator serves as the PREA Compliance Manager; however, due to his absence, the Assistant Facility Administrator was serving as the Acting Facility Administrator/PREA Compliance Manager during this time period.

The site visit was conducted March 22-23, 2016 with the introductions and tour of the program unit occurring on the afternoon of March 22nd. A tour was conducted by the Program Director, accompanied by the Program Directors from the other two program units located on the campus. During the tour, staff members were observed to be involved with the residents, providing direct supervision. Randomly selected residents; randomly selected direct care staff members from all

shifts; specialized staff members; and a contractor were interviewed. During the site visit, additional documentation was provided as requested. A close-out meeting was held at the conclusion of the site visit with the OYDC/CC Program Director and the Assistant Facility Administrator. The G4S Senior Regional Director was present on 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:

Facility Policy 10-25, Prison Rape Elimination Act (PREA), and Policy 1919 of the Florida Department of Juvenile Justice (FDJJ 1919) are aligned and jointly serve as the guidelines and strategies for staff regarding the application of the PREA standards. The PREA Policy provides that the program unit is contractually obligated to adopt and comply with the PREA standards outlined in FDJJ 1919. The policies include the zero-tolerance approach for the implementation of the PREA standards regarding 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 and a review of the organizational chart confirmed that the Facility Administrator manages the facility and serves as the PREA Compliance Manager. The Assistant Facility Administrator stated that there is sufficient time and authority to implement and coordinate the activities related to PREA compliance. The Facility Administrator reports to the G4S Senior Regional Director.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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:

Policies 10-25 and 10-8 and management review of the shift schedules ensure adequate levels of staffing for all shifts. Based on the Shift Briefing Reports, Shift Supervisor Reports, staff interviews, and observations, the staffing ratio is maintained according to the ratio of 1:8 during the waking hours and 1:12 during the sleeping hours. The campus has a hold-over process that ensures adherence to the ratios and the program unit reports no deviations from the staffing plan. The facility reports that the average daily number of residents is 50 and that the average daily number of residents on which the staffing plan was predicated is also 50.

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 shift staffing ratios; staffing patterns; deployment of cameras; documentation of unannounced rounds; and observations during the completion of the assessment.

Policy 10-25 provides that the Administrative Duty Officer conducts unannounced rounds at least once a month and that the visits are documented. Unannounced rounds are completed and documented by the Assistant Facility Administrator. The documentation provides for the notation of related concerns and any observations that would be classified as a risk. A review of documentation and an interview with the Assistant Facility Administrator confirmed that unannounced rounds occur. The Shift Supervisors conduct unannounced rounds during their shifts and document such rounds on the Shift Briefing Report. The PREA Policies prohibit staff from alerting other staff of the occurrence of the unannounced visits and the practices exercised by the Assistant Facility Administrator support the Policies.

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:

Based on interviews with staff and residents it was determined that cross-gender pat-down searches and cross-gender strip searches are not conducted in the program unit, in accordance with Policy 10-3. The Policy addresses staff conducting searches of residents and provides the details of each type search and requires documentation of the searches. The 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.

Staff interviews revealed that training and discussions regarding the searches of all residents include that they are done in a professional and respectful manner as also directed in policy. The search of a transgender or intersex resident will be referred to medical. Direct care staff interviews and a Nurse interview indicated that they are aware of the requirement of Policy 8-14, where transgender or intersex residents are not to be searched or physically examined for the sole purpose of determining their genital status and that no such searches occurred during this audit period.

Observations and resident and staff interviews are in accordance with 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 living units.

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 ensures that disabled residents are provided equal opportunity to participate in or benefit from resident education to protect them from sexual abuse and sexual harassment. Policies 10-25 and FDJJ 1919 require that residents are not to be used as interpreters or readers, unless in limited circumstances where an extended delay in obtaining an interpreter could compromise safety, first responder duties, or the investigation. Staff 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.

Other staff members may be used as interpreters, according to the staff interviewed, or outside contacts would be made to obtain assistance. Staff also reported that residents are not used as interpreters for other residents. 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 is available to shift supervisors.

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:

Policies 3-16 and FDJJ 1919 address 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 prohibited activities and the Policies provide directions regarding background checks and screenings. Any incident of sexual harassment is considered regarding the hiring or promotion of an employee.

The interview with the Regional Human Resource Manager and a review of a sample of personnel files confirmed the practices that are aligned with the agency personnel policies. There was confirmation by the Regional Human Resource Manager that it is the employee's continuous duty to disclose any related misconduct. The review of the personnel documents revealed that they include background checks; signed acknowledgement forms regarding PREA related information and information received. The staff interview also revealed that hiring and promotion decisions are based on background information obtained and according to the considerations required by the policies and standards. Documents show that employees receive a background re-screening every five years as required. The policies and facility practice provide that the omission of information regarding misconduct is grounds for termination of employment.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The program unit reports no substantial expansion since August 20, 2012 and the camera system has not been enhanced.

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 provide 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 Assistant Facility Administrator is familiar with and has 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 campus. 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. There was also confirmation that services would include access to a Sexual Assault Nurse Examiner for a forensic examination when requested. The Sexual Assault Assistance Program of the Treasure Coast provides the facility with posters and literature which were observed on campus during the site visit. 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 and staff interviews confirm that an administrative or criminal investigation would be completed for all allegations of sexual abuse and sexual harassment. The Policies identify the agency responsible for conducting the criminal and administrative investigations and instructs staff to cooperate with investigations. Interviews with staff confirmed their awareness of the policies, including that all referrals of allegations for investigations are documented. The Office of Inspector General follows unit specific

policy in conducting administrative investigations. There was one allegation made in 2014 and the administrative investigation was completed in the last 12 months. There were two allegations during the past 12 months where one received an administrative and criminal investigation and the other was an administrative investigation. Investigative reports and a review provided by the Senior Regional Director indicate staff members' cooperation with the administrative and criminal investigations.

Through posted information, the campus provides parents/guardians and visitors with information on how to report allegations of sexual abuse and sexual harassment allegations. The Parent Handbook is provided to each parent or guardian and identifies the staff who will notify them with an update regarding specific situations regarding their child, including emergency room visits; physical altercations with staff or other residents; and allegations of staff misconduct. Review of investigative and related reports show the notification of parent/guardian regarding an allegation of staff misconduct. The Florida Department of Juvenile Justice's 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:

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 confirmed initial and refresher training regarding PREA. 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. A staff training unit is located on the campus within the administrative building that serves the entire campus. A training class was in progress during the site visit. Staff meetings are also used to share and review PREA and other information.

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:

Policy FDJJ 1919 and the review of training documents and the FDJJ training guide for training sessions for volunteers and contractors provide for the compliance of this standard. Documentation in the personnel files show that contractors receive training on their responsibilities regarding the zero-tolerance of sexual assault and sexual harassment and how to report any allegations or incidents. Additionally, the training roster for volunteers and the education contractors confirm that the training occurs. The training guide used for contractors and volunteers was also reviewed. Interviews with the Regional Human Resource Manager, Principal and Program Director support that contractors and volunteers receive the appropriate PREA related training.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 10-25 and a review of documentation acknowledging resident participation in PREA education sessions document that residents are provided age-appropriate PREA information. 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 this program unit. Interviews with a Case Manager and residents confirmed PREA education during the intake process and refresher sessions. A checklist is completed for each new admission and it includes the notation for PREA education to be checked off. The Case Manager shared that she also ensures that each resident receives the information by conducting or coordinating reviews twice a month.

During the resident interviews it was noted that the residents were not really familiar with the services provided by the Sexual Assault Assistance Program of the Treasure Coast and their confidentiality practice. A corrective action plan was developed during the site visit and has since been implemented resulting in an update that included the specific information regarding the services of the rape crisis center. The documented training, including where residents had written their names was submitted.

Staff members may assist with the PREA education for residents that are limited English proficient, visually impaired or otherwise disabled, or have limited reading skills. Additional support services may be obtained from the Registry of Certified Court Interpreters, Florida Registry of Interpreters for the Deaf, and staff members that work at other G4S facilities. The PREA information is posted within the program unit and residents are provided a Youth Handbook that contains information for reporting allegations.

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:

The facility staff members do not conduct administrative or criminal investigations. Staff interviews confirmed that they are aware of the investigative agencies responsible for investigating PREA related allegations. Florida DJJ Policy addresses the training of the Office of the Inspector General Investigators, including the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Training is provided to investigative staff regarding conducting investigations in FDJJ settings. Campus management has been provided the information sheet, disseminated by FDJJ, regarding appropriate protocols for PREA investigations for sharing with local 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 for their particular area, as well as the general PREA training. The specialized training is developed by FDJJ and is accessible to medical and mental health staffs online and is documented through the Staff Development & Training SkillPro System. Prior to and during the site visit, some staff had not completed the specialty training modules. A corrective action plan was agreed upon on site and later implemented resulting in all required staff members completing the specialized training modules. The training documents have been reviewed to confirm completion of the training. The medical staff does not conduct forensic examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9-1, 9-3, 10-25, 8-14, and FDJJ 1919 ensure that all youth admitted to the facility are properly screened. Staff and resident interviews, Policies 10-25 and FDJJ 1919, and a review of documentation confirmed that screenings include that residents are also screened for risk of victimization and abusiveness. This vulnerability screening occurs within 24 hours of intake, whether the youth is transferred from another facility or is a new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The information obtained from the VSAB is aligned with what is required by the standard, including but not limited to prior sexual victimization or abusiveness; the youth's self-identification; current charges; offense history; and intellectual or developmental disabilities. The residents and a Therapist responsible for administering this screening stated that it is done the same day of admission and a review of VSABs confirmed the practice.

An interview with a Therapist who administers the VSAB revealed that information is obtained from the resident, parent/guardian and related paperwork. The Therapist stated that the administering of the VSAB is treated like a conversation; also, questions are asked and probing is done where needed. Additional screening and assessment tools are used to obtain information to aid staff in meeting the individual needs of the residents. According to the Therapist, the information from the VSAB is accessible to the medical and mental health staffs and information is communicated on a need to know basis. The files were observed to be maintained in an orderly and confidential manner. The residents interviewed were able to identify specific areas that are inquired about through the administration of the VSAB and they stated that similar questions related to safety are asked periodically by their Therapist, Case Manager and 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 8-14, 9-3 and FDJJ 1919 provide guidance to staff regarding the information from the VSAB and other risk screening instruments and outline how the information is to be used.

The information gleaned from the VSAB and other screening instruments is used in the overall classification of the resident, assisting staff in determining bed, education and other program assignments with the goal of keeping all residents safe and based on their individual needs.

There has not been a resident placed in administrative isolation or controlled observation during this audit period due to concern for their safety from sexual assault. The controlled

observation rooms will not be used for protective custody regarding the risk of sexual abuse but may be used for brief periods for a resident to calm down and re-gain control of acting-out behavior. According to Policy 10-14, control observation may be used in response to a dangerous crisis situation when staff cannot control highly aggressive and violent behavior with less restrictive measures, or when less restrictive measures are inappropriate.

Placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status is prohibited by Policy 8-14. It also prohibits staff from considering the identification as an indicator that the resident 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 Policy 8-14.

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 provide multiple internal ways a resident may report, including how a report may be made privately regarding sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may lead to the aforementioned. Residents may report allegations of sexual abuse or sexual harassment through access to the FDJJ abuse hotline and the abuse hotline for the victim advocacy agency. Staff may also use the abuse hotline to privately report sexual abuse and sexual harassment of residents.

Resident and staff interviews revealed other identified methods a resident may report allegations of sexual abuse or sexual harassment. The internal methods a resident may report include completion of a Let's Talk form requesting to speak to a specific staff member; completion of a grievance form; talk to any staff member; completion a Sick Call Request form; and third parties may report allegations. Access to writing tools is provided for residents so that they are able to complete the forms.

The interviews conducted with staff and residents also 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, anonymously, 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 needed. A review of investigative reports indicates that an allegation was reported anonymously and received an administrative investigation by the Office of Inspector General.

Policies and staff interviews provide that staff members are required to document verbal reports and to report the information immediately to their supervisor which is reported up the chain and relayed to the Central Communications Center and the appropriate investigating entity. Staff receives this information on how to report sexual abuse or sexual harassment through policies and procedures, training, meetings, and posted information.

Standard 115.352 Exhaustion of Administrative Remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 and facility practice provide that grievances regarding sexual abuse or sexual harassment may be completed and submitted at any time. The resident is not required 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 stated that an allegation may be reported by completing a grievance form.

A grievance alleging sexual abuse would be immediately provided to the Facility Administrator and the procedures for reporting allegations of sexual abuse would be initiated. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. The content of the grievance is reported and an investigation will be conducted by the Office of Inspector General, Florida Department of Children and Families and/or the Okeechobee County Sheriff's Office.

Policy 10-25 and FDJJ policy direct staff on reporting sexual abuse and sexual harassment of residents. A review of investigative reports indicated allegations that were reported by another staff member as required by Policy. The Policy also provides 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, through the PREA education received, that they will not be punished if a report is made in good 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 that the Facility Administrator ensures accessibility of residents to an outside victim advocacy agency for emotional support services. A Memorandum of Understanding (MOU) for the provision of victim support services has been completed and signed. The details of the services had not yet been thoroughly reviewed with the residents prior to the site visit. A corrective action was implemented after the site visit and a PREA education session was conducted with all residents receiving additional information about the specific services and the confidentiality practices of the victim advocacy agency. A roster of the residents, where they had printed and signed their names, was submitted to the auditor.

The information for reporting sexual abuse was observed on postings in the facility which included how to contact the advocacy agency for services. Services to be provided that are contained in the MOU were confirmed through a telephone interview with the Victim Services Director for the State Attorney's Office and the Sexual Assault Assistance Program of the Treasure Coast. In addition to other support services, the 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 residents' interviews, the program unit provides residents with reasonable and confidential access to attorneys or Probation Officers. A review of Policy, Youth Handbook, and other documentation and according to resident interviews, reasonable access to parents or legal guardians is provided. The residents interviewed were aware of the visitation days, weekly phone calls, 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:

Policies 8-3 and 10-25 address third-party reporting and interviews revealed that residents are aware that third-party reporting of sexual abuse and sexual harassment can be done. All residents interviewed stated that they knew someone who did not work at the facility that they could report to regarding allegations of sexual abuse and that the third-party could report the allegations for them to be investigated. Staff interviews revealed their knowledge of third-party reporting and that they can receive allegations from third-parties. Information regarding reporting allegations is provided through observed postings that are located in areas of the campus that are accessible to visitors, 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. Staff members are instructed to immediately report all allegations of sexual abuse or sexual harassment to their immediate supervisor and the supervisors and management are to ensure the report to the Central Communications Center (CCC) and investigative entities as appropriate.

Policy 10-25 prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. The CCC will make appropriate notifications to senior FDJJ management who will make notification to management overseeing the facility where the alleged abuse occurred. Policy 10-25 requires the Facility Administrator to notify the alleged victim's parents or legal guardians. If the resident is under DCF Custody, the Case Worker will be notified and if applicable, the attorney of record will be notified of the allegation within 14 days of receipt of the allegation, according to the Policy. A review of investigative and related reports indicates notification of the parent/guardian.

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. According to interviews with clinical staffs and document review, the residents are informed at the initiation of services of the limitations of confidentiality and the clinical staff's duty to report.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 10-25 and FDJJ 1919 instruct staff to take immediate action to keep residents safe when they learn 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 identify steps they would take to protect residents who are at substantial risk of imminent sexual abuse. The steps

identified included immediately separating the residents, implementing one-on-one staff supervision; and alerting shift supervisor for further instruction. Residents indicated that during the intake process, there was discussion about their feelings concerning their own safety and that their 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:

Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator must notify the head of that facility where the alleged abuse occurred, according to FDJJ 1919. 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 has not been a report about an incident of abuse occurring while the resident was confined in another facility. The Assistant Facility Administrator 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 outlines the first responder duties which are generally to separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Initial training and refresher training and updates are conducted with staff through a combination of online statewide training and training conducted on campus. Staff interviews revealed that they are aware of the steps to take if they are the first responder to an alleged incident. FDJJ 1919 directs that if the employee first responder is not direct care staff, they should request that physical evidence is preserved and direct care staff should be notified.

During the past 12 months there were three investigations completed for this program unit. One administrative investigation was substantiated for sexual misconduct. Allegations from that same incident were also investigated by the Okeechobee Sheriff's Office and judicial proceedings are pending. This was not an incident that involved first responder duties or the collection of physical evidence.

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 staff members that were interviewed are 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)

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. The retaliation monitor has been identified as the Assistant Facility Administrator. An interview

revealed an understanding of observing for whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation. The items mentioned in the interview that would be monitored were aligned with the standard and Policy such as observations; reviewing reports, including Let's Talk and grievance forms; and room changes. The program unit reports that there has not been an incident of retaliation during the past 12 months.

Three investigations were completed during the past 12 months. The investigative findings for one report that was made anonymously resulted in the allegations being unfounded. The other two reports involved the same staff member. One investigation substantiated findings of sexual misconduct by the staff as the results of an administrative investigation. The second report regarding two allegations against that same staff member were made by a different resident after his placement in another program and those administrative findings were unfounded and unsubstantiated.

After the first allegation was made against the staff, the staff member was placed on no contact status regarding residents and was suspended pending the outcome of the investigations by the Office of Inspector General and the Okeechobee Sheriff's Office. Subsequently the staff member was terminated as a result of the administrative investigation. The staff member was later arrested, as a result of the criminal investigation, and prosecution is pending regarding allegations of sexual abuse. The incident review report documents that the resident, who has since been released, received individual therapy by mental health staff and was assisted in processing the incident.

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 is not used at this facility for residents who allege or would have suffered sexual abuse.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 10-25 and FDJJ 1919 and staff interviews provide that administrative investigations are conducted by the Office of the Inspector General and criminal investigations are conducted by the Okeechobee County Sheriff's Office. The Department of Children and Families (DCF) are also called when there is an allegation of sexual abuse. The Policies direct facility staff to cooperate with investigations and FDJJ 1919 further provides that an investigation is not terminated because the source recants the allegation. The Assistant Facility Administrator is familiar with the Policies. A review of the investigative reports and related documents show the contacts made as prescribed by policies, such as the Central Communications Center, parents, DCF, and local law enforcement where the allegations are criminal in nature.

The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings and the investigators receive training on the related policies. The Assistant Facility Administrator maintains the information sheet developed by FDJJ that is to be given to the law enforcement investigator. The information sheet provides law enforcement investigators with the expected protocols related to PREA investigations that are criminal in nature. The documentation reviewed shows that allegations that are criminal in nature are investigated by local law enforcement and that that substantiated allegations are referred for prosecution. The case that was substantiated for sexual abuse by the Okeechobee Sheriff's Office is pending judicial proceedings. The Senior Regional Director remains abreast of the case through periodic status checks.

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 policy and practice of the Office of Inspector General, responsible for administrative investigations, impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 provides that the victim is informed when the investigation is completed and Policy 10-25 provides that the Facility Administrator notifies the victim or victim's parents or legal guardians. The Policies also state that the victim must be informed of the findings and the outcome of the staff or resident perpetrator as outlined in the standard and the Policies when the investigative findings are substantiated or unsubstantiated. There have not been any investigations regarding resident-on-resident abuse during the past 12 months.

One report of allegations of sexual abuse was investigated by both the Office of Inspector General (OIG) and the Okeechobee County Sheriff's Office. The OIG investigation determined that the allegations were substantiated as sexual misconduct and the Sheriff's Office investigation concluded that there was enough evidence to charge the staff member regarding the allegation of sexual abuse. The resident was informed of the results of the investigations and was provided individual therapy as a result of the incident. Judicial proceedings are still pending for the former employee. The Senior Regional Director periodically conducts status checks with the Okeechobee Sheriff's Office for updates regarding the case. There was another administrative investigation conducted regarding the same staff member with the findings of unfounded and unsubstantiated. Those allegations against the staff member were made by a resident who had been released and was in another placement when the allegations were made. The staff member had been terminated and arrested when these allegations were made.

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 for disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance policy. Policy supports that disciplinary sanctions for violations of agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff. Policies provide that terminations or resignations by staff that would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. Management staff is aware of the related policies. The facility reports that during this audit period, one staff member violated policy. The staff member was suspended after the allegation was made and subsequently terminated after the completion of the administrative investigation. As a result of the criminal investigation, the former employee was arrested and legal proceedings are pending.

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:

FDJJ 1919 addresses this standard, including requiring that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. It also provides that contractors and volunteers who engage in sexual abuse are reported to law enforcement and to relevant licensing bodies. Policy 10-25 prohibits sexual activity between residents and volunteers and contract personnel. There is documentation that supports that PREA training is provided to contractors and volunteers through acknowledgement forms and training rosters. During this audit period, there have been no allegations of sexual assault or sexual harassment regarding a contractor or volunteer.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

☒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 provide that an administrative process is in place for dealing with violations, including resident-on-resident sexual abuse. Policy 8-1 and staff interviews support that the formal process holds the residents accountable for their actions. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse. Sexual activity between residents is prohibited and court or administrative processes and sanctions occur when it has been determined that the sexual activity was coerced. There have not been allegations of resident-on-resident abuse reported in the past 12 months. According to Policy, residents would be disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact. Disciplinary isolation is not used in the program unit.

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 where required. 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. Mental health services were provided to a resident regarding an allegation against staff while in the facility. The resident was involved in therapy sessions with his Therapist.

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, including providing for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. The practice is that all residents are seen by medical and mental health staffs on the same day of admission. Interviews with medical and mental health staffs and a review of documentation support that residents are seen on the same day of admission as part of the intake process. Additionally, a Therapist is assigned to each hall in the housing unit and conduct individual, group and family sessions with each resident.

Policy supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and those staff, based on their need to know. A review of files show that medical and mental health staff members maintain documentation of the services they provide to the residents. Medical and mental health staffs discussed their knowledge of informed consent, in accordance with policy. Residents who are 18 years and older sign a different informed consent form.

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, 10.25 and FDJJ 1919; staff interviews; and current practices revealed that emergency medical care and crisis intervention services will be provided by medical and mental health staffs as determined by health care staff. Processes and services are in place for a sexual abuse victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate. Forensic examinations will be conducted at the Raulerson Hospital emergency room by a Sexual Assault Nurse Examiner provided by the Sexual Assault Assistance Program of the Treasure Coast.

A review of files indicate that medical and mental health staff members maintain secondary materials that document services to residents and these staffs are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policies and understood by the medical and mental health staffs that treatment services will be provided at no cost to the

victim; whether or not the victim names the abuser; or whether or not the victim cooperates with the investigation. The interviews with the Health Services Administrator and the Director of Treatment Services revealed that residents would have access to unimpeded access to emergency services and that medical and mental health services are determined according to their professional judgment.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

☒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 7-30 and interviews with medical and mental health staff members confirmed that on-going medical and mental health care will be provided for sexual abuse victims and resident abusers, as appropriate. The Health Services Administrator and the Director of Treatment Services were able to articulate the follow-up care that would be provided at the facility.

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 and interviews demonstrate that medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or a juvenile facility. Ongoing clinical services were provided to a resident regarding allegations of sexual abuse. The Policy also provides for a mental health practitioner to conduct a mental health evaluation within 60 days on a resident who discloses youth-on-youth abuse. The staff confirmed that this could be done.

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:

Policy 10-25 and FDJJ 1919 provide for an incident review to be conducted within 30 days of the completion of an investigation in accordance with the standard. During this audit period, there were three completed investigations. One was determined as unfounded and two involved the same staff member. The sexual abuse incident reviews were completed.

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 Policies provide that the report from the incident review team is provided to the Facility Administrator, who also serves as the PREA Compliance Manager. The interview with the Assistant Facility Administrator as an identified team member revealed familiarity with the Policies and understanding of the purpose of the review process which is also demonstrated through the completed sexual abuse incident reviews.

A form/format has been developed by FDJJ to capture the required information for documentation of an incident review team meeting. The reports identified the attendees and document the discussions that included motivating factors; physical barriers; review of staffing levels and review of policy and procedures. The reports also allow for recommendations to the Facility Administrator. One report contained recommendations which were implemented.

Standard 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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

Florida DJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with directives by FDJJ and Policy 1-5. 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)

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:

FDJJ 1919 provides guidance regarding this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. The Policy also states that an annual report is prepared that will provide an assessment of the agency's progress in addressing sexual misconduct.

The annual report is prepared in accordance with policy and approved as required. A comparative report has been prepared and it is also obvious from facility and program staff interviews, discussions with the statewide PREA Coordinator; observations; and document review that the agency has compared the results of annual reports. The review of the reports has gleaned information that is used to continuously improve policies; procedures; practices; and training on a statewide basis. The annual reports are made 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 securely stored and maintained for at least 10 years after the initial collection date, unless statutes require otherwise. According to the Policy, the aggregated sexual abuse data from all facilities will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified that there are no personal identifiers, as required.

AUDITOR CERTIFICATION:

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

Shirley L. Turner

Auditor Signature

April 20, 2016

Date