PREA AUDIT: AUDITOR'S SUMMARY REPORT

JUVENILE FACILITIES

Name of Facility: Polk Halfway House				
Physical Address: 2145 Bob Phillips Road, Bartow FL 33830				
Date report submitted: January 13, 2015				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
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Telephone number: 678-895-2829				
Date of facility visit: July 21-22, 2014				
Facility Information				
Facility Mailing Address: Same as Physical Address				
Telephone Number: 863-519-5581				
The Facility is:	☐Military	☐County	☐Federal	
	☒Private for profit	☐Municipal	☐State	
	☐Private not for profit			
Facility Type:	☐Detention	☒ Correction	☐Other:	
Name of PREA Compliance Manager: Denise Lovett			**Title:**	Facility Administrator
Email Address: Denise.Lovett@us.g4s.com			**Telephone Number:**	863-519-5581
Agency Information				
Name of Agency: G4S Youth Services, LLC				
Governing Authority or Parent Agency: G4S plc				
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, ext. 202
Agency Wide PREA Coordinator				
Name: Bobbi Pohlman-Rogers			**Title:**	JJDPA/PREA Director
Email Address: bobbi.pohlman@us.g4s.com			**Telephone Number:**	954-818-5131

AUDIT FINDINGS

NARRATIVE:

The Polk Halfway House is operated by G4S Youth Services, LLC through a contract with the Florida Department of Juvenile Justice (DJJ). It is a moderate risk facility for male juvenile offenders that range from 10 to 14 years of age. Specialized mental health services are provided to residents with moderate to serious mental or emotional disturbances whose level of functioning make them unsuitable for a general offender program but not at the level of requiring intensive mental health services. The program and services that the residents receive include mental health; medical; case management; individual, family, group therapeutic interventions; life skills training; recreation; and specialized community re-entry preparedness.

The mental health staff helps residents work on personal issues and provide individual therapy and daily group therapy services. A therapist works with the family on identified family treatment needs. A Licensed Practical Nurse is available within the program and provides sick call, makes medical appointments as needed and is part of the treatment team. Oversight to medical services is provided by the Registered Nurse at another G4S facility, located in close proximity down the street from the Polk Halfway House. Education services are provided by the Polk County School District and the courses provided are English, Mathematics, Science, Social Studies, Reading, and one elective course. Residents are provided the opportunity to attend non-denominational religious services once a week on a voluntary basis.

There are five levels to the program plus an orientation period. Incentives increase as the resident progresses through each level. As the incentives increase so do the program expectations and the responsibilities of the resident. In order to obtain a level advancement the resident must meet all requirements of that level and his treatment and performance plan goals. The designed facility capacity is 24. Forty (40) residents were admitted to the facility during the past 12 months. The length of stay is six to nine months.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The Polk Halfway House program is maintained in one single-story building that contains a housing unit; dayroom; multi-purpose room; dining area; three classrooms, with one containing the library; small medical office; small maintenance office with an area for storing tools; laundry room; storage and other closets; and an extended back porch. There are administrative offices in the front of the building and the control room is located in the front at the entrance of the building. The housing unit contains 10 rooms that are occupied by one to three residents. Mental health staff offices are located on the housing unit. The area of the grounds located in the rear of the building is used for recreation and contains a basketball goal and a kickball field.

The multi-purpose room provides space that allows for residents to congregate in a comfortable and orderly manner. Use of the day room, located off the housing unit, is a part of the behavior management level system. When earned, residents may use the day room to play games and participate in activities that are aligned with the incentives of a particular level.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in the facility prior to the site visit. The Pre-Audit Questionnaire was uploaded to a flash drive with some policies and little supporting documentation and was received prior to the site visit. Supplementary supporting documentation and other policies had been assembled for review and presented at the beginning of the site visit.

The on-site audit was conducted July 21-22, 2014. An entrance meeting was held, followed by a comprehensive tour of the facility. During the tour, staff members were observed directly supervising and interacting with residents. Randomly selected staff, specialized staff and residents were interviewed. The results of the interviews confirmed that both groups had been involved in PREA training. Staff members were interviewed from all shifts. During the on-site audit, additional documentation was provided as requested and in a timely manner.

An interim report of findings was submitted in August 2014 and the eight following standards were not met: 115.315; 115.321; 115.331; 115.335; 115.351; 115.352; 115.353; and 115.365. Corrective actions have been implemented and those standards have been met.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25, The Prison Rape Elimination Act (PREA), provides guidelines for implementing the facility's approach to complying with the requirements of the PREA standards and the zero tolerance of all forms of sexual abuse and sexual harassment. The policy contains definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The Policy also identifies the Facility Administrator as the PREA Compliance Manager. Policy 3-3, Employee Standards of Conduct and Performance, contains prohibited behaviors for staff and includes sanctions for employees who have participated in prohibited behaviors.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

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

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 requires a periodic internal review of the staffing plan to ensure adequate levels of staffing and staff interviews confirm this practice. A review of documents showed that a Staffing Plan Assessment has been conducted by the DJJ Statewide PREA Coordinator based on the staffing requirements of the contract as well as the ratios stated in the standards. Reportedly, there have not been any deviations from the staffing ratios as outlined in the contract. The facility uses holdovers, when needed, to comply with the required ratios for the contract and the standard. The Policy requires supervisory level staff to conduct unannounced rounds. Interviews and documentation confirm that the unannounced rounds are conducted by the Assistant Facility Administrator and the Facility Administrator.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 10-3 and staff and resident interviews revealed that cross-gender strip searches and cross-gender frisk searches are not conducted. Policy 10-3 has been revised and addresses staff conducting searches of transgender and intersex residents. Facility policy and resident and staff interviews supported that residents are able to shower, perform bodily functions, and change clothing without being viewed by the opposite gender. Policy 10-25 and staff interviews supported that transgender or intersex residents shall not be searched or physically examined for the sole purpose of determining the resident's genital status.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 includes that residents may not be used as interpreters unless an extended delay in obtaining an interpreter could compromise the resident's safety, the performance of the first responder duties, or the investigation of the resident's allegation. The facility practice is to use bilingual staff members as interpreters and the assistance of education and mental health staff, as needed. Interviews with staff and residents confirmed that staff members are used as interpreters and to provide other assistance to ensure residents' understanding of the information provided. The PREA pamphlets are provided in other dominant languages and according to staff, DJJ may be contacted for assistance, if needed.

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)

The facility adheres to the guidelines in Policy 3-16, Employee Recruitment and Selection, and DJJ Policy 1800. The policies prohibit hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited within the standards and discusses background checks and screenings. A review of the policies and procedures, interviews with staff, and a review of a sample of documentation revealed that background checks and the local child abuse registry check are supposed to be conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

The installation of the camera system began in early 2014 and the complete installment was recently completed. The system supports the direct supervision of the residents which is provided by staff. There are a total of 16 cameras located in the primary areas frequented by residents. The monitor is located in the Facility Administrator's office where she and the Assistant Facility Administrator may have constant access.

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)

Victim advocacy services have been obtained and a Memorandum of Understanding (MOU) has been signed with Peace River Center Rape Recovery & Resource Center. Policy 7-30 provides that all services related to sexual assault allegations are provided at no cost to the victim. According to staff interviews, residents who experience sexual abuse will have access to forensic medical services at the local hospital.

Policy 10-25 states that the facility is not responsible for conducting administrative or criminal investigations. According to the Policy and DJJ 1919, the DJJ Office of the Inspector General (OIG) is responsible for conducting administrative investigations; the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse; and the local law enforcement agency is responsible for conducting criminal investigations.

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)

Policy 10-25 and DJJ 1919 Procedures identify the units that will conduct the criminal and administrative investigations and instructs staff to cooperate with the investigations. Related policies are published on the DJJ website. During the past 12 months, there were no allegations of sexual abuse or sexual harassment reported.

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)

The PREA training covers the areas referenced in the standard. Staff training rosters are maintained and staff has received the PREA training as provided. A review of documentation and staff interviews confirmed that staff members receive the PREA training.

Standard 115. 332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 Procedures require that volunteers and contractors be trained on their responsibilities regarding the agency's zero tolerance of sexual assault and sexual harassment. There are three volunteers that conduct religious services at the Polk Halfway House and they have received the required 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)

Policy 10-25 states that all residents are provided PREA information during the intake process. Staff and resident interviews and a review of documentation confirm that residents are provided PREA education during the intake process. Staff members in the education and treatment units and direct care staff may assist with the PREA education for residents that are limited English proficient, visually impaired, otherwise disabled, or have limited reading skills. It was also reported that assistance could be provided from another facility. The PREA information is provided on posters and pamphlets that are accessible to all residents. Pamphlets are available in the two other dominant languages of youth that are admitted to the facility.

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)

The FDJJ 1919 Procedures state that staff in the OIG will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Appropriate training is provided to investigative staff regarding conducting investigations in the DJJ settings.

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)

The facility's Nurse and mental health staff have received the specialized PREA related training. Documentation supports that the training is provided.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 9-1 and 9-2 provide information concerning the classification process. It is required that all residents are screened for risk of victimization and abusiveness within 24 hours of intake. The screening is conducted using the DJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). The VSAB gleans the information outlined in the standard. Interviews and documentation confirm that the VSAB is used. The resident's risk may be re-assessed periodically through interaction with treatment 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)

Three Policies address this standard, 8-14, 9-2 and 10-18. The Policies reference the information used from the VSAB and outlines what is used to help determine housing and program assignments with the goal of keeping all residents safe. Policy prohibits placing gay, bisexual, transgender or intersex residents in specific housing or other assignments solely based on how they self-identify or their status. Documentation did not reveal any resident held in isolation or segregated housing because they were at risk for sexual victimization during the past 12 months.

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)

Policy 8-3 provides information on residents' access to the Florida Abuse Hotline. There are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation(s) that led to abuse. A resident may file a grievance; complete the Conference Request Form indicating a specific staff member to meet with; talk to any staff; and third parties may report allegations to staff.

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)

Policy 8-4 was revised to more clearly state that the informal process of the grievance system was not required when the grievance concerned sexual abuse or sexual harassment. The completed grievance forms are placed in a locked box and are collected by the Assistant Facility Administrator. According to the Policy, all allegations of sexual abuse or sexual retaliation will be given to the Facility Administrator and that she will respond immediately. The Policy provides a timeline for other grievances to be responded to within 72 hours of receipt of the grievance.

Policy 8-4 allows for receipt of reports from third parties and that third parties may assist residents in filing grievances. Policy 10-25 provides staff with the required information for reporting sexual abuse and sexual harassment of residents.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Policy 10-25 addresses this standard. Victim advocacy services have been arranged and a MOU has been signed. The advocacy agency staff confirmed that advocacy services will be provided to victims as outlined in the MOU. The services that will be provided also include resident and staff education. The facility provides residents with reasonable and confidential access to attorneys or other legal representation and reasonable access to their parents or legal guardians.

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)

Third party reporting is contained in Policies 10-25 and 8-3. Information is provided through posters that are located in areas of the facility, visible to the public. The facility's letter to the

parents/guardians from the Facility Administrator contains information on how the parent or guardian may file a grievance. The FDJJ website contains information for third party reporting regarding juvenile facilities.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policies 1-5, 8-3, 10-25 and FDJJ Policy 1919 support the requirement that all staff report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. Staff interviews show that they are aware of the policies regarding their reporting duties and understand that they are mandated reporters.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 instructs staff to take immediate action to keep residents safe when they learn that there is substantial risk of imminent threat of sexual abuse. Interviews with staff confirmed their knowledge of this policy and they were able to verbalize measures they would take to protect residents who are at substantial risk of imminent sexual abuse.

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)

FDJJ 1919 Procedures address this standard and identifies the contacts to be made and the process. It was reported that, during the past 12 months, the facility has not received any reports from a resident about an incident of abuse occurring while they were confined in another facility.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

☒Meets Standard (substantial compliance; complies in all material ways with the standard

for the relevant review period)

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 provides the requirements for the first responder. Interviews with staff confirmed their awareness of their responsibilities in responding to allegations of sexual abuse. During this audit period there was not an incident that involved first responder duties of secure or non-secure staff.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

The coordinated response has been developed and documented and provides for the appropriate responses by various staff to an incident of sexual assault.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒Standard Not Applicable

This standard is not applicable. The Polk Halfway House does not maintain any collective bargaining agreements.

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 addresses the facility's efforts to provide protection to residents and staff from retaliation. The retaliation monitors have been identified and charged with the responsibility of observing whether or not retaliation occurs after a resident or staff reports allegations of sexual abuse or cooperates with an investigation.

Policy directs staff to report any neglect or violations of responsibilities by other staff that may have contributed to an incident of sexual abuse or retaliation. There have been no reports of allegations of sexual abuse at this facility during this audit period.

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒Standard Not Applicable

This standard is not applicable. Segregated housing is not used at this facility.

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)

Policy 10-25 and FDJJ 1919 addresses this standard. According to Policy 10-25, administrative investigations are conducted by the DJJ Office of Inspector General and criminal investigations are conducted by the local law enforcement agency. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. Both Policies direct facility staff to cooperate with the investigations.

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)

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

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 10-25 and FDJJ 1919 allows for the victim to be informed that the investigation has been concluded. At the conclusion of an investigation, the victim or the victim's parents or legal guardian will be notified when the investigation has been completed.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Policy 3-3, Employee Standards of Conduct and Performance, addresses disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero tolerance policy.

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)

Policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. It also provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement agencies and to relevant licensing bodies.

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)

The Resident Handbook outlines the administrative process and the measures to be taken regarding major violations, including sexual attack of peers or staff and lewd and lascivious behavior. According to the Handbook and staff, the resident could be referred to law enforcement for charges and possible removal from the facility. There are no reports of resident-on-resident sexual abuse during this audit period

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)

Policy 9-1 requires a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual victimization. Policy states that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners. Medical and mental health staff members maintain documentation of the services they provide to the residents.

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)

Policy provides for access to emergency services. Staff interviews and a review of current files revealed that documentation regarding medical and crisis intervention services will be maintained by medical and mental health staff. Staff interviews also revealed that the documentation would include the timelines of services and the other requirements of the standard.

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)

This standard is addressed in Policy 10-25. Interviews with medical and mental health staff confirmed their awareness of the policy and how the policy would be implemented. Staff interviews revealed the professional opinions to be that the medical and mental health services are consistent with the community level of care and that appropriate ongoing medical and mental health services can be provided at the facility.

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)

Policy 10-25 and FDJJ 1919 Procedures provide for and identify an incident review team to review all incidents within 30 days of the conclusion of an investigation. The Policy outlines the requirements of the standard for discussion and review by the team. The team members review all significant incidents. Interviews confirm their understanding of the policy and the purpose of the team and that it will operate according to the standard.

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)

FDJJ Procedures 1919, the Department's FY 13-14 PREA Incident Report and interviews with staff confirmed that DJJ collects incident-based, uniform and aggregated data regarding allegations of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The agency provides DOJ with data as requested.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 addresses this standard on a statewide basis. The DJJ PREA Coordinator will review the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives. 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.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

FDJJ 1919 Procedures provide that all data collected will be maintained for at least 10 years after the initial collection date. According to the Policy, the report will be approved and posted on the agency's website, accessible to the public, as required by the standard.

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

January 13, 2015

Date