# PREA AUDIT: AUDITOR'S SUMMARY REPORT

# JUVENILE FACILITIES

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|---|---|---|---|---|
| **Name of Facility: St. Johns Youth Academy** | | | | |
| **Physical Address: 4500 Avenue D, St. Augustine, FL 32095** | | | | |
| **Date report submitted: November 16, 2015** | | | | |
| **Auditor information: Shirley L. Turner** | | | | |
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| **Telephone number: 678-895-2829** | | | | |
| **Date of facility visit: October 19, 2015** | | | | |
| **Facility Information** | | | | |
| **Facility Mailing Address: 4500 Avenue D, St. Augustine, FL 32095** | | | | |
| **Telephone Number: 904-829-8850** | | | | |
| **The Facility is:** | ☐ Military | ☐ County | ☐ Federal | |
| | ☒ Private for profit | ☐ Municipal | ☐ State | |
| | ☐ Private not for profit | | | |
| **Facility Type:** | ☐ Detention | ☐ Correction | ☒ Other: Residential | |
| **Name of PREA Compliance Manager: Kristine Harshaw** | | | **Title:** | **Asst. Facility Admin.** |
| **Email Address: kristine.harshaw@sequelyouthservices.com** | | | **Telephone Number:** | **904-829-8850** |
| **Agency Information** | | | | |
| **Name of Agency: Sequel Youth & Family Services** | | | | |
| **Governing Authority or Parent Agency: NA** | | | | |
| **Physical Address: 1131 Eagletree Lane, Huntsville, AL 35801** | | | | |
| **Mailing Address: Same as Above** | | | | |
| **Telephone Number: 256-880-3339** | | | | |
| **Agency Chief Executive Officer:** | | | | |
| **Name: John Stupak** | | | **Title:** | **Chief Executive Officer** |
| **Email Address: johnstupak@sequelyouthservices.com** | | | **Telephone Number:** | **215-284-5043** |
| **Agency Wide PREA Coordinator** | | | | |
| **Name: Sonja Schierling** | | | **Title:** | **Sequel PREA Coordinator** |
| **Email Address: sonyaschierling@sequelyouthservices.com**<br>**Telephone Number: 941-526-8763** | | | | |

# AUDIT FINDINGS

## NARRATIVE:

The St. Johns Youth Academy is located in St. Augustine, Florida and is operated by Sequel Youth and Family Services through a contract with the Florida Department of Juvenile Justice (DJJ). It is a 70-bed residential facility that serves male juvenile offenders between the ages of 14-18 who have been classified as high risk. The program provides Mental Health Overlay Services and utilizes a cognitive behavioral approach in the delivery of mental health and substance abuse treatment services. In addition to mental health and substances abuse services, the program provides case management, medical, education, and recreation services on site.

Mental health services are provided under the management of the Clinical Director. A consulting psychiatrist visits the facility every two weeks. The Director of Nursing manages the medical clinic and a contract physician visits the facility. The school provides education and vocational services and is operated by education staff through the St. Johns County School District. The school offers courses in English, Mathematics, Science, Social Studies, and an elective course. The facility serves as a GED testing site.

Resident progress and the privileges and responsibilities associated with progress are evaluated by the residents' ability to effectively and honestly engage in the treatment process. Residents are held accountable for positive participation in the program, adhering to the core norms, and for completing various treatment assignments and expectations. In addition to other program requirements, residents are required to complete a series of Focus Areas organized on the principles of the Balanced and Restorative Justice Model. The Focus Areas are Accountability, Skill Development and Community Safety; each area builds upon the other.

## DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is housed in one main building and the front entrance contains a reception area, reception office, administrative offices, and a conference room. Beyond the front entrance are six dormitories; a control room; six classrooms; medical clinic area; kitchen; two multi-purpose rooms; intake area; additional offices; and storage rooms. Each of the six dormitories has an outside recreation area adjacent to it and an office for the teacher and a day room is located inside of each dormitory. Female staff members announce their presence prior to entering a dormitory. The outside grounds contain a large area that can accommodate an array of recreation and other activities, including Family Day which is held each quarter.

Youth admitted to the facility stay for a period of 9-12 months. The population during the on-site audit was 67. The number of staff employed at the facility is 82. The facility consists of single cells and there are no multiple occupancy cells or open bay housing units. Isolation is not used at this facility.

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## SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various areas of the facility prior to the site visit. Photographs were taken of the posted notices and the photographs were electronically sent to this Auditor, noting their posted locations. An initial telephone conversation was held between this auditor and the Assistant Facility Administrator/PREA Compliance Manager to review the PREA audit process. The Pre-Audit Questionnaire, facility policies and supporting documentation were uploaded to a flash drive, which was received by the Auditor prior to the on-site audit. After reviewing the Questionnaire, written notes were provided to the PREA Compliance Manager seeking clarity and additional information. Clarification and other documents were provided along the way during the audit process.

The on-site audit was conducted on October 19, 2015. An entrance meeting was held with the PREA Compliance Manager. After the meeting, a staff member from the overnight shift was interviewed by the Auditor. Following the interview, a comprehensive tour of the facility was conducted. During the tour, staff members were observed to be providing direct supervision to the residents. Robert Lanier, Certified PREA Auditor, assisted with the audit. Ten direct care staff members and 10 residents were interviewed. Twelve specialized staff interviews were conducted. The residents and staff interviewed were aware of how to report sexual assault and sexual harassment. A summary of the audit findings was provided to the Assistant Facility Administrators.

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)

**Auditor Comments:**

The facility has a zero-tolerance PREA Policy, 5.29, which details how the facility will implement its approach to preventing, detecting, and responding to sexual abuse. The facility's PREA Policy is used in concurrence with the Florida Department of Juvenile Justice's PREA Policy 1919 (FDJJ 1919). Both policies contain definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. A staff member has been identified as the PREA Compliance Manager; she also serves as one of the two Assistant Facility Administrators.

**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:**

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

**Standard 115.313 Supervision and Monitoring**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29 addresses the facility staffing plan and its requirements. The Policy provides that documentation is required when deviations from the staffing plan occur. The facility reports that there have been no deviations from the staffing plan. A review of the documented staffing plan shows the staff assignments and Policy 5.29 states that staffing is continuously monitored and that adjustments are made as needed, which was also supported by staff interviews. A system is in place to ensure that the ratios of 1:8 during the waking hours and 1:12 during the sleeping hours are maintained. A staffing plan assessment has been conducted and documented by the DJJ statewide PREA Coordinator.

Policy 5.29 and facility practice provide for unannounced rounds that are completed by intermediate/higher level staff. The Policy includes that staff will not alert other staff when unannounced rounds are occurring. A review of documentation and staff interviews confirmed that unannounced rounds occur.

**Standard 115.315 Limits to Cross Gender Viewing and Searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29 addresses this standard. Staff members are prohibited from searching a transgender or intersex resident to determine the resident's genital status. Cross-gender strip searches, cross-gender pat-down searches, and cross-gender visual body searches are prohibited by the Policy. Staff training includes the searching of residents, including residents who may be transgender or intersex. The viewing of residents by opposite gender staff while they are showering, changing clothes, and performing bodily functions is not permitted and female staff members announce their presence when entering a dormitory. The facility reports no cross-gender pat-down, strip or body cavity searches of residents. All staff and residents interviewed revealed that cross-gender searches do not occur. Interviews with staff and residents confirmed this practice.

**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 5.29 addresses the facility not relying on resident interpreters or resident readers. The facility will utilize support services through Language Line Solutions in partnership with the Florida Department of Health. Employees of Sequel Youth and Family Services may also provide assistance in Spanish. Staff interviews confirmed that residents are not used as interpreters. PREA information brochures are available in languages other than English.

**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:**

Policy 5.29 addresses the standard and provides guidelines for background checks on all employees. FDJJ 1919 provides the process that also includes the elements of the standard. A review of documentation and interviews with staff show that applicants and employees are asked about previous misconduct. Documentation provided and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are 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)

**Auditor Comments:**

The facility uses the current camera system to support the direct supervision by staff. The agencies are in the process of upgrading the video monitoring system.

**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:**

The facility has a Memorandum of Understanding with the victim advocacy agency, Betty Griffin House/Safety Shelter of St. Johns County, Inc. The document provides for the completion of forensic examinations in cooperation with Flagler Hospital; access to the agency's rape crisis hotline; follow-up advocacy and counseling services; and support planning for treatment services to continue or begin when residents are released. Policy 5.29 addresses the availability of victim advocacy services to residents and services provided to the victim at no cost. There has not been a need for a forensic medical examination during the audit period for this facility.

According to Policy 5.29 and FDJJ 1919, the facility is not responsible for conducting administrative or criminal investigations. 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 local law enforcement is responsible for conducting criminal investigations. The PREA Compliance Form which contains the PREA requirements regarding investigations will be provided to law enforcement investigators as required by DJJ.

**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:**

Policy 5.29 and FDJJ 1919 require that allegations of sexual abuse or sexual harassment are referred for investigation and identify the agencies that will conduct the criminal and administrative investigations. According to FDJJ 1919 facility staff is to cooperate with the OIG investigations. There has been one allegation made and it is currently being investigated by the OIG. Information regarding the referral of allegations of sexual abuse or sexual harassment for an investigation and other PREA related information is posted on the Sequel Youth and Family Services and the DJJ websites. PREA related information is also posted in the facility, accessible to the public.

**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:**

Policy 5.29 provides information regarding staff training. Employees receive training and updates and specifics related to the standards as needed and through DJJ for additional and specific training. The staff training includes the key areas referenced in the standard. The overall PREA training is primarily provided by DJJ through online courses and specific training is also provided at the facility. Between trainings, the facility provides refresher information. Staff interviews support that training is provided in accordance with the standard and the Policy.

**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 5.29 requires volunteers and contractors who have contact with residents to be trained on their responsibilities and the DJJ prepared course regarding sexual assault prevention, detection, and response is used. FDJJ 1919 also addresses the training of contractors and volunteers. Receipt of the training was acknowledged through interviews with contract staff.

**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 5.29 requires that all residents receive age-appropriate training about PREA and how to report incidents or suspicions of sexual misconduct, the facility response, and non-retaliation for reporting. Residents receive PREA education and there are provisions to provide it through accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled, as needed. Support services will be provided by Language Line Solutions and agency staff.

**Standard 115.334 Specialized Training: Investigations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

FDJJ 1919 addresses that staff in the OIG will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. The investigators have been trained in conducting allegations in the FDJJ 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)

**Auditor Comments:**

Policy 5.29 and FDJJ 1919 address this standard. Medical and mental health staff members have completed on-line specialized training provided by FDJJ. Forensic medical examinations will not be conducted by the facility medical staff.

**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:**

Policy 5.29 addresses the use of the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) instrument. It is administered to determine the resident's risk of victimization and abusiveness and other related information. The instrument is completed on each resident. Staff and resident interviews and a review of documentation confirmed that the screening is being conducted. Policy 5.29 requires that residents be reassessed within prescribed timelines.

**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:**

According to Policy 5.29, the information obtained from the VSAB is used to assist in determining housing and other program assignments. Staff interviews and a review of VSABs supported the policies, procedures and practices. Residents confirmed through their interviews that VASBs are being administered. Isolation is not used at this facility. Policy 5.29 prohibits placing gay, bisexual, transgender, or intersex residents into separate housing or any other assignment based solely on such identification or status. The facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

**Standard 11 5.351 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:**

Policy 5.29 provides for internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that lead to abuse. A resident may talk to any staff member; complete a grievance form and place it in the grievance box; complete a form requesting to speak to a particular staff member; utilize the DJJ hotline number; and third parties may report allegations. Staff members are required to document verbal reports. Reporting information is also provided in FDJJ 1919. PREA related information is posted within the facility, accessible to all residents. Resident and staff interviews revealed that they are aware of the reporting methods. The allegation that is currently under administrative investigation was reported through the grievance system.

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**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:**

Policy 5.29 addresses resident grievances. If the grievance is PREA related, the resident is instructed to give it to identified staff or place it in the grievance box. The resident is not required to use the informal process for any situation regarding sexual abuse or sexual harassment allegations. When a grievance is received, it is treated as an allegation of abuse and the reporting procedures are implemented for an investigation by the OIG, DCF or local law enforcement. There was one grievance received and the allegation is currently being investigated by the DJJ Office of the Inspector General. The grievance was treated as an allegation and was reported as required.

**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 5.29 provides for residents to have access to outside victim advocacy services and a Memorandum of Understanding exists between the facility and the Betty Griffin House/Safety Shelter of St. Johns County, Inc. The facility ensures that residents will have access to an outside victim advocate for emotional support services related to sexual abuse.

Staff and resident interviews confirmed that residents have confidential access to their attorney or other legal representative and access to their parents or legal guardians. All residents interviewed could verbalize the visitation and telephone process.

**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:**

The facility provides methods for third-party reporting of sexual abuse as supported by Policies 5.29 and FDJJ 1919. Related information is posted in areas of the facility accessible to the public. PREA information is available on the DJJ and the Sequel Youth and Family Services websites regarding the reporting of sexual abuse or sexual harassment.

**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:**

Policy 5.29 and FDJJ 1919 address this standard. All staff members are required to report any allegation of sexual misconduct. Allegations must be reported to the Central Communications Center (CCC), DCF and local law enforcement, as required by mandatory reporting laws and facility and DJJ policies. FDJJ 1919 instructs staff members not to reveal any related information to anyone other than those who are involved in treatment, investigation and other security and management decisions.

**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:**

According to Policy 5.29 and staff interviews, when staff learns that a resident is subject to substantial risk of imminent sexual abuse, actions will be taken to protect the resident. There has not been a case of imminent risk; however, the facility reported an incident of when measures were taken just as a precaution as it relates to the current allegation that is under investigation by the OIG. Staff interviews revealed the protective measures that would be taken when it is determined that a resident is at 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)

**Auditor Comments:**

According to Policy 5.29, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Facility Administrator will notify the head of that facility or the appropriate office as soon as possible but no later than 72 hours and the contact will be documented. FDJJ 1919 requires notifying the appropriate investigative agency of all allegations of sexual abuse. There has not been a report of any allegations of sexual abuse occurring to a resident while 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)

**Auditor Comments:**

The staff first responder duties are incorporated in Policy 5.29 and are aligned with the requirements of FDJJ 1919. The facility Policy also addresses the requirements of non-security staff. Non-security staff members are required to alert security staff immediately upon learning of any sexual abuse or harassment. They are also required to attempt to secure any possible evidence and remove the victim from any immediate danger. Interviews confirmed that staff members are knowledgeable of their duties.

**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's coordinated response plan is aligned with FDJJ 1919 and the requirements of the standard. Interviews with staff revealed that they are familiar with the institutional plan. The plan coordinates the actions to be taken among facility first responders and other staff in response to an 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 any collective bargaining agreements.

**Standard 115.367 Agency Protection Against Retaliation**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29 addresses this standard and it is the responsibility of the PREA Compliance Manager who also serves as an Assistant Facility Administrator, to monitor for retaliation. The Policy requires that if the retaliation conduct is identified, the monitoring would be conducted for at least 90 days and longer if needed, regarding staff. The retaliation monitoring for a resident will be for the duration of his stay. There have been no incidents of retaliation reported.

**Standard 115.368 Post Allegation Protective Custody**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

This standard is not applicable; segregated housing or isolation is not used 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)

**Auditor Comments:**

Policy 5.29 and FDJJ 1919 provide direction for this standard. Administrative investigations are conducted by the OIG and criminal investigations are conducted by local law enforcement and DCF. An investigation is not terminated solely because the source of the allegation recants the investigation. There have not been any allegations investigated that were criminal in nature. Policy FDJJ 1919 directs staff to cooperate with the OIG 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)

**Auditor Comments:**

Policies 5.29 and FDJJ 1919 address this standard. Regarding administrative investigations, the standard of a preponderance of the evidence for determining whether allegations are substantiated is imposed.

## Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29 and FDJJ 1919 provide that the victim is informed when an investigation has been concluded. At the conclusion of an OIG investigation, the victim or the victim's parents or legal guardian will be notified unless the allegation is unfounded. According to Policy 5.29, the facility will also notify the resident in writing and will have the resident sign the notification acknowledging receipt of the information. The facility has notified the resident of the progress regarding the allegation that is currently under investigation by the OIG. The resident signed the notification acknowledging receipt of the update information.

## 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 5.29 and FDJJ 1919 support this standard. The Policies provide for disciplinary sanctions for staff including termination for violation of the PREA policies regarding sexual abuse and sexual harassment. The staff involved in the current incident under administrative investigation, has been terminated by the facility due to the facility's determination of staff misconduct.

## 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:**

Policy 5.29 and FDJJ 1919 state that any contractor or volunteer engaging in sexual abuse of residents will be subject to referral to local law enforcement regarding criminal charges and to relevant licensing bodies. Both Policies require that the contractor or volunteer be prohibited from having contact with residents. No contractor or volunteer has been reported to law enforcement or any investigative agency for allegations of sexual abuse.

## 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:**

Policy 5.29 and FDJJ 1919 address this standard. Residents found in violation of the facility's zero-tolerance policy will receive disciplinary sanctions after a formal disciplinary process. There have been no findings of resident-on-resident sexual abuse. Disciplinary isolation is not used at this facility.

## 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:**

Policy 5.29 addresses this standard. Residents who disclose prior sexual victimization or who disclose previously perpetrating sexual abuse during an intake screening will be provided a follow-up meeting with a medical and mental health practitioner. These meetings are available from the first day of admission to the facility. Staff interviewed confirmed awareness of the procedures and verbalized how the intake process would incorporate this process.

**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:**

Policy 5.29 addresses the sections of this standard, including that treatment services to every victim be provided at no cost to the victim. The Policy further states that victims will be provided on-going medical and mental health treatment that includes testing for Sexually Transmitted Infections (STI) and counseling. Interviews with staff confirmed their knowledge of the procedures and that the scope and nature of the services will be based on the professional judgment of the medical and mental health staff.

**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:**

Policy 5.29 provides that residents will be allowed on-going medical and mental health treatment, to include STI testing and counseling. Policy 5.29 provides that all residents have access to mental health evaluations and treatment. Evaluations and appropriate treatment will be provided to victims and abusers. Policy 5.29 and FDJJ 1919 address ongoing medical and mental health care for sexual abuse victims and abusers.

**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 5.29 and FDJJ 1919 provide information regarding the incident review team and its role. The Policies detail the facility and agency staff positions that would make-up the sexual abuse incident review team and they provide the purpose of the team and guidelines for its function. Interviews with staff confirmed knowledge of the construction of the team, when it will be assembled, and that the After Action Review form would be used to document the meeting process and findings.

**Standard 115.387 Data collection**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29, FDJJ 1919 and interviews with staff confirmed that DJJ and the facility collect incident-based, uniform and aggregated data regarding allegations of sexual abuse using a standardized instrument. The Policies require the collection of accurate, uniform data for every allegation of sexual assault. The facility/DJJ will provide DOJ with data as requested.

**Standard 115.388 Data Review for Corrective Action**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 5.29 and FDJJ 1919 address this standard and provide for annual reports. A review is conducted of the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives within DJJ. The DJJ Annual Report is posted on the agency's website and a comparison is made regarding the previous year's data.

**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:**

Policies 5.29 and FDJJ 1919 requires that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed.

**AUDITOR CERTIFICATION:**

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

Shirley L. Turner

Auditor Signature

November 16 , 2015

Date