PREA AUDIT: AUDITOR'S SUMMARY REPORT

JUVENILE FACILITIES

Name of Facility: Bartow Youth Academy				
Physical Address: 2415 Bob Phillips Road, Bartow, FL 33830				
Date report submitted: January 12, 2015				
Auditor information: Shirley Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
Email: shirleyturner3199@comcast.net				
Telephone number: 678-895-2829				
Date of facility visit: July 17-18, 2014				
Facility Information				
Facility Mailing Address: Same as Physical Address				
Telephone Number: 863-537-8986				
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: Dr. Adam Bazini			**Title:**	Facility Admin.
Email Address: adam.bazini@us.g4s.com			**Telephone Number:**	863-537-8986
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 Above				
Telephone Number: 813-514-6275				
Agency Chief Executive Officer				
Name: James C. Hill, Jr.			**Title:**	President
Email Address: jim.hill@us.G4S.com				
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 Bartow Youth Academy (BYA) is a 28 bed moderate risk facility that serves male juvenile offenders between the ages of 14 and 19. It is located in Bartow, Florida and operated by G4S Youth Services, LLC through a contract with the Florida Department of Juvenile Justice (DJJ). The facility houses residents who have been assessed as Borderline Developmental Disabled and whose level of cognitive functional limitations would make their placement unsuitable in a general offender program.

The services and programs provided at the BYA include: mental health services and substance abuse treatment including individual, family and group counseling; medical; education; specialized life skills training; recreation; and spiritual activities. There have been 42 staff members employed at the facility and 37 youth admitted to the facility during the past 12 months. Medical and mental health staffs are employed by the facility. The physician visits the facility at least once per week. The education staff is provided through the Polk County School District.

The BYA is a six to nine month program with the average length of stay being eight months. The behavior management system is based on the residents' successful completion of their treatment and performance goals; daily performance; compliance with scheduled activities; self-management; maintaining a positive attitude; and developing positive relationships with staff and other youth. There are three levels in the program plus and orientation period. For a resident to move to the next level, he must meet all the requirements of that level and present an application to the treatment team. As the level advances, the responsibilities and the incentives for the resident increases and positive behavior must be maintained.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The grounds contain one main building and a modular unit that is used as a classroom and for other activities. Located in the main building are administrative and support staff offices; multi-purpose room areas that are used as classrooms and may be used for other activities; two housing units; medical clinic area; and a control room. The grounds provide for outside recreation and leisure activities. The housing units are separated by the control room, where the control room operator has a view of the dayrooms of each housing unit and down the main hall leading to the classrooms, offices and the front entrance.

A camera system supports the direct supervision provided by the staff. Cameras are located strategically on the inside and outside of the building. The main viewing and monitoring of the cameras are conducted by the staff operating the control room. The facility is equipped with single shower and bathroom stalls. The facility has made arrangements for the provision of victim advocacy services.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in the facility at least six weeks prior to the on-site audit. Photographs were taken of the posts and were electronically sent to this Auditor, noting the locations. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received prior to the on-site audit. After reviewing the information, notes were sent to the Facility Administrator who also serves as the PREA Compliance Manager and followed up with a telephone call. In response to the issues discussed, additional documents were submitted as requested and clarity of information was provided prior to the site visit.

The on-site audit was conducted July 17-18, 2014. An entrance meeting was held, followed by a comprehensive tour of the facility. During the tour, staff members were observed to be interacting with residents and providing direct supervision. Randomly selected staff, specialized staff and residents were interviewed. The responses of staff and residents during their 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.

An interim report was submitted in August 2014 that contained eight standards that were not met. Those standards were as follows: 115.315; 115.321; 115.331; 115.335; 115.351; 115.352; 115.353; and 115.365. Corrective actions were implemented during a corrective action period and the 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 provides guidelines for implementing the facility's approach to complying with the requirements of the PREA standards including, zero tolerance toward all forms of sexual abuse and sexual harassment. The policy contains definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

Policy 3-3, Employee Standards of Conduct and Performance, contains prohibited behaviors for staff and includes sanctions for employees who have participated in the prohibited behaviors. The Facility Administrator serves as the PREA Compliance Manager.

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 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)

The number of staff to hire and the staffing ratios are a part of the facility's contract with DJJ. The required ratios for the day and evening are 1:7 and during the night is 1:9. For the purpose of the contract, all trained staff may be included in the required ratios. However, based on the facility's direct care staffing, the ratios of a minimum of 1:8 during the waking hours and 1:16 during the sleeping hours are met.

The DJJ statewide PREA Coordinator completes a Staffing Plan Assessment based on this standard which shows a review of the staffing. Intermediate/higher level staff conducts unannounced rounds. The Facility Administrator and the Assistant Facility Administrator rounds are recorded on the PREA Unannounced Walk Through form that contains the date, shift/time, staff's name, and comments section.

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 the opposite gender viewing their private parts. Policy 10-25 states 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 and DJJ 1919 Procedures prohibit the use of residents as interpreters and readers 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. Interviews confirmed that staff members are used as interpreters for the two other dominant languages of the residents.

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 Policies 3-16 and DJJ-1800. The policy prohibits hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited within the standard. A review of the policies and procedures, interviews with staff and a sample review of documentation revealed that measures are in place for conducting background checks.

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 camera system has been installed for approximately one year. There are a total of 27 cameras which are located inside and outside of the facility. The system has the capacity to store data for 30 days. The upgrades to the system include access for viewing from the offices of the Facility Administrator and the Assistant Facility Administrator.

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 developed with the Peace River Center's Victims Services Rape Recovery Program. Policy 7-30 addresses medical services being provided at no cost to the victim.

The BYA does not conduct administrative or criminal investigations. Administrative investigations are conducted by the DJJ Office of the Inspector General (OIG) and criminal investigations are conducted by local law enforcement. The Florida Department of Children and Families are called to investigate allegations of child abuse. Reportedly, there have not been any incidents or allegations of sexual abuse 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)

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.

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 has been enhanced and covers the areas referenced in the standard. Staff training rosters are maintained and all staff members are required to receive the PREA training. Refresher training is provided through staff meetings where a PREA related issue is reviewed. A review of documentation and staff interviews confirmed the formal training and the reviews conducted during staff meetings.

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)

Contractors and volunteers are required to review and are given the opportunity to ask questions about the PREA information provided. A prepared document outlines information concerning PREA and the accompanying responsibilities. Contractors and volunteers acknowledge their understanding of the information. The document includes the reference to the zero tolerance policy, information on how to report incidents of sexual contact; and the document has to be signed and dated.

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)

According to Policy 10-25, all residents are provided PREA information during the intake process. Staff and resident interviews and a review of documentation confirm that a Therapist explains the zero tolerance policy to the residents during the intake process. The resident is provided the opportunity to ask questions. Information is provided in the resident handbook and on posters. 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. Additionally, staff report that DJJ may be contacted for assistance to meet the needs of the residents assigned to the facility that may require additional support services.

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)

FDJJ 1919 states 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)

Documentation has been presented showing that all mental health staff members have received specialized training. Documentation was provided during the on-site audit showing that the Nurse has completed the training.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

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 FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior. The instrument ascertains the information prescribed in the standard. The resident may be re-assessed periodically through the treatment meetings.

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)

This standard is addressed in Policies 8-14, 9-2 and 10-18. They provide that the information used from the objective screening instrument is 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. The facility does not use isolation.

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)

Policies 8-3 and 10-25 address resident reporting. Policy 8-3 provides information on the 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 the abuse. A resident may file a grievance; complete a form requesting to talk with a specific staff member; or talk to any staff member. The grievance and other written requests may be placed in a locked box, where it is collected by the Assistant Facility Administrator.

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 contains the grievance system for residents. The policy has been revised to express more clearly that residents do not have to use the informal process regarding allegations of 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 he will respond immediately. The Policy provides a timeline for other grievances to be responded to within is 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)

Arrangements have been made for outside victim advocacy services to be provided. A review of the MOU states that the services include education and training for residents and staff, counseling services, and referral services for victims. The advocacy services were confirmed by an agency staff member.

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 FDJJ website contains information for third party reporting regarding the 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 and 10-25 address this standard and there is the requirement that all staff report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. Interviews conducted with staff confirm that they are aware of the policies regarding their reporting duties and they acknowledged 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 risk. The facility reports that in the past 12 months, it was not determined that any resident was subject to 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 addresses this standard and identifies the contacts to be made and the process. Reportedly, the facility has received no reports from a resident of an incident of abuse occurring while they were confined in another facility during this audit period.

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 outlines the requirements for the first responder. Interviews with staff confirmed their awareness of their responsibilities in responding to allegations of sexual abuse. During the past 12 months there have been no allegations that a resident was sexually abused.

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 facility response plan has been enhanced to provide more specific information for staff regarding responsibilities and coordinated actions.

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 Bartow Youth Academy 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 for 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.

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 DJJ 1919 state that Florida Department of Children and Families and local law enforcement investigate child abuse allegations and that the DJJ Office of Inspector General conducts administrative investigations. Policies 10-25 and 1919 state that staff members are expected 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 imposes a standard of a preponderance of the evidence for determining whether allegations are substantiated for administrative investigations.

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 DJJ-1919 allows for the victim to be informed that the investigation has been concluded. At the conclusion of an OIG investigation, the victim or the victim's parents or legal guardian will be notified by receiving a copy of the final report.

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 addresses disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment policies. Reportedly, no staff has been disciplined, terminated, or resigned prior to termination for violation of the facility's sexual abuse or sexual assault policies during the past 12 months.

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)

The facility 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 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 applicable sanctions for major rule violations which include sexual attack on peers and lewd and lascivious behavior. According to the Handbook, law enforcement may be contacted and the resident removed from the facility as well as legal charges may be filed. During the past 12 months, there have been no allegations of resident-on-resident sexual abuse. Isolation is not used at the Bartow Youth Academy.

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.

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)

Documentation regarding medical and crisis intervention services, in the case of an incident or allegation of sexual abuse, would be maintained by medical and mental health staff. Interviews revealed that the documentation would include the timelines of services and the 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)

According to Policy 10-25 ongoing medical and mental health evaluations and appropriate treatment will be offered to each victim. Staff interviews confirmed their awareness of the policy and revealed that the medical and mental health services are consistent with the community level of care. The interviews further revealed that appropriate ongoing medical and mental health services can be provided at the facility, if needed.

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 provides for and identifies an incident review team to review all incidents within 30 days of the conclusion of an investigation. The Policy highlights the requirements of the standard for discussion and review by the team.

Standard 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

DJJ 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)

The FDJJ 1919 Procedures address this standard on a statewide basis. According to the Procedures, the 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)

Procedures for DJJ 1919 provide that all data collected will be maintained for at least 10 years after the initial collection date. 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 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

January 12, 2015

Date