PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: September 6, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: August 8, 2017			
Facility Information			
Facility name: Brevard Group Treatment Home			
Facility physical address: 3905 Grissom Parkway, Bldg. 7a, Cocoa, FL 32926			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 321-637-1866			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Roscoe Griffin			
Number of staff assigned to the facility in the last 12 months: 29			
Designed facility capacity: 30			
Current population of facility: 29			
Facility security levels/inmate custody levels: Non-Secure			
Age range of the population: 12-15			
Name of PREA Compliance Manager: Roscoe Griffin		**Title:** Program Director	
Email address: roscoe.griffin@aspirehp.org		**Telephone number:** 321-637-1866	
Agency Information			
Name of agency: Aspire Health Partners			
Governing authority or parent agency: *(if applicable)*			
Physical address: 5151 Adamson Street, Orlando, FL 32804			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-514-6275			
Agency Chief Executive Officer			
Name: Dick Jacobs		**Title:** Chief Executive Officer	
Email address: dick.jacobs@aspirehp.org		**Telephone number:** 407-245-0045	
Agency-Wide PREA Coordinator			
Name: NA		**Title:**	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE

The Brevard Group Treatment Home is located in Cocoa, Florida and provides residential treatment services to male juvenile offenders through a contract between the Florida Department of Juvenile Justice (FDJJ) and Aspire Health Partners. The program and services provided by the facility include but are not limited to: individual, group and family counseling; education services; community service; medical services; mental health services; and recreational activities. The average length of stay for residents is seven months.

The preparation for the facility's audit included a conference call with the Auditor; the facility's Program Director who currently serves as the PREA Compliance Manager; FDJJ statewide PREA Coordinator; and a Program Manager from the FDJJ Central Office. During the conference call, introductions were made and the audit process was reviewed and discussed. A printed sign announcing the site visit and the Auditor's contact information was provided to the facility more than six weeks prior to the date of the site visit. Copies of the signs were made by the facility staff and placed in various locations around the facility. Pictures were taken of the postings and were sent to the Auditor via email. The locations of the signs were identified and included various areas in the administration and housing buildings.

The completed PREA Pre-Audit Questionnaire, policies, and other documentation were uploaded to a flash drive and mailed to the Auditor. After an assessment of the information provided on the flash drive, a written review was provided to the Program Director requesting clarification of information and additional documentation that should be sent and/or be available during the site visit. Additionnaly, this auditor made contact by phone with a representative from the victim advocacy agency that will provide services to the facility upon request.

The site visit was conducted on August 8, 2017. The Auditor was greeted by the Program Director; Senior Director, of Aspire Health Partners' Central Office; Administrative Assistant; and Clinical Manager. An entrance conference was held to review the process and the agenda for the site visit. Upon completion of the entrance conference, a comprehensive tour of the facility was conducted by the Program Director which included all areas of the facility and the outside grounds. During the facility tour, observations revealed that staff members were providing direct supervision to the residents and the staffing ratio was being met.

The printed notifications of the PREA site visit were observed posted in the areas previously identified with the pictures received by the Auditor including the entrance door to the administrative building and in the lobby. There were posters and signs sighted in various locations regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. Sick call and grievance boxes and forms, used for reporting allegations, are maintained in the housing building and accessible to all residents. There are also forms located in the housing building which provide residents the opportunity for self-referrals for mental health services and a dedicated locked box for residents to deposit the self-crisis mental health referral form. After the conclusion of the comprehensive facility tour, a summary, where no deficiencies were identified was provided to the Program Director, Senoir Director and Clinical Manager.

The interviews conducted during the site visit included 10 residents and six direct care staff members from all three shifts. There were an additional 13 interviews conducted including administrative, treatment, contract, and volunteer staff. The interviews with staff and residents indicated they had received PREA training and refresher training, as needed. Residents, staff members, contractor and volunteer were cooperative during the interviews. Additional supporting documentation was reviewed during interviews with specialized staff and as requested.

An exit conference was held at the conclusion of the the site visit with the Program Director, Senoir Director and Clinical Manager. A summary of the audit findings was provided as well as the information regarding the completion of and the timeline regarding the PREA audit written report. There were no problem areas identified during the exit conference.

DESCRIPTION OF FACILITY CHARACTERISTICS

Brevard Group Treatment Home consists of two buildings. One building contains a reception area where visitors sign in/out; administrative offices; classrooms; computer laboratory/conference room; multi-purpose room; dining hall; and kitchen. The second building includes the housing area; dayroom or common area; medical clinic; office; direct care staff work station; small dayroom for specific activities; storage closet; and laundry room. The bathroom and the configuration of the showers provide residents with a reasonable amount of privacy.

The outside grounds provide ample space for large muscle and other activities. There is a large area filled with sand which is known as "The Pit." The outside grounds also include three basketball goals and a ropes course. The facility has cameras strategically placed on the inside and cameras are located on the outside. There is a host of PREA related and reporting information located in both buildings. Signs are posted on the outside and inside of the housing building instructing female staff to announce their presence upon entering the building.

Forty-two residents have been admitted to the facility in the past 12 months and 38 staff members have been assigned to the facility in the past 12 months. The facility provides residents with the opportunity to participate in community service and other off-campus activities. Based on a resident's phase in the program, he may also be eligible to receive a home pass. A behavior management system exists for residents which includes the use of achievement levels and a weekly point system to earn privileges for demonstrating positive behavior and consequences for negative behavior.

A Registered Nurse coordinates the medical services and provides medical services along with a Licensed Practical Nurse. A HIV Counselor/Educator and a Physician visit the facility weekly. Forensic medical examinations will be conducted at the local hospital. Mental health services are coordinated and provided by the Clinical Manager. There are three Senoir Youth Counselors within the mental health unit. A Phychiatrist visits the facility on a weekly basis. Education services, coordinated by the Lead Teacher, are provided through the Brevard County Public School System. A Case Manager ensures the coordination of services to address the individual needs of residents. Direct care staff members are responsible for the general supervision and management of the residents in all daily activities, on and off campus.

SUMMARY OF AUDIT FINDINGS

The were no allegations of sexual abuse or sexual harassment reported in the past 12 months. Administrative investigations will be investigated by the Florida Department of Juvenile Justice, Office of Inspector General. Allegations of child abuse are also reported to the Florida Department of Children and Families. Allegations of sexual abuse which are criminal in nature are reported to the Cocoa Police Department.

The facility was found in compliance for all applicable PREA standards as shown below:

Number of standards exceeded: 0

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 4

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04, Prison Rape Elimination Act (PREA), is the facility's zero-tolerance policy regarding all forms of sexual abuse and sexual harassment and it outlines the approach for preventing, detecting, and responding to such allegations. The Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919) serves as the overarching and comprehensive policy. Policy A04 is aligned with FDJJ 1919. The PREA policies and related policies outline the strategies for addressing the components of the PREA Standards and contain definitions of the prohibited behaviors and address sanctions to be used when the PREA related policies are violated.

The PREA and related policies provide guidelines to staff regarding zero-tolerance strategies that include the following components:
*prevention and responsive planning;
*training and education;
*risk screening;
*reporting;
*official response following a resident report;
*investigations;
*discipline;
*medical and mental care; and,
*data collection and review.

The Program Director serves as the PREA Compliance Manager. He confirmed his role during the interview and a review of policies and the facility's organizational chart verified the role of the PREA Compliance Manager. The Program Director is directly supervised by the Aspire Health Partners' Senoir Director. The Program Director stated during the interview and it was observed that he takes the time and has the authority required to fulfill his PREA related duties. The interview also revealed how the Program Director involves the staff members in the facility's efforts in achieving and maintaining PREA compliance. Interviews conducted with random staff confirmed their awareness of the Program Director also serving as the PREA Compliance Manager.

Standard 115.312 Contracting 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses staffing, supervision/monitoring, and unannounced rounds. The policy outlines the considerations for staffing and provides guidance to staff in adhering to the staffing ratios of the contract of 1:8 during the waking hours and 1:12 during the sleeping hours. The work schedules and obsevations during the comprehensive facility tour revealed the adherence to the staffing ratios and the facility policy. The staffing plan provides for the staffing ratios to be met, a hold-over system and the use of part-time labor pool of direct care workers to ensures adherence to the staffing plan. During the interview with the Program Director, there were discussions of the considerations for the development and maintenance of the staffing plan, including the identification of blind spots, security/program needs and the contract requirements.

The annual Staffing Plan Assessment was completed on May 22, 2017 by the FDJJ statewide PREA Coordinator in conjunction with the Program Director and includes but is not limted to a review of the following: staffing plan; monitoring system; resources available and committed to ensure adherence to the staffing plan; and the occurrence of unannounced rounds. The form summarizes the review is signed and dated by both the FDJJ statewide PREA Coordinator and the Program Director. During the comprehensive of the facility tour, the Program Director pointed out additional cameras and the array of PREA information posted throughout the facility.

The interview with the Program Director; review of the staffing plan and the annual Staffing Plan Assessment; work schedules; and other documents verified the facility complies with the current staffing plan. The policy provides for compliance to the staffing plan except during limited and exigent circumstances and the deviations be documented. The facility reports there were no deviations from the staffing plan and this was also documented on the Staffing Plan Assessment. The average daily number of residents on which the current staffing plan was predicated is 30, which is the designed facility capacity.

A review of a sample of documented unannounced rounds for all shifts and the policy support unannounced rounds are conducted by higher level and intermediate level staff. The unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment and are documented on a dedicated form which provides for noted observations in identified areas. The Clinical Manager who is identified, along with other management staff, conduct unscheduled visits and ensure staff members do not alert other staff members regarding the unannounced visits and as according to the policy. She revealed that she changes the hours she conducts the rounds so as not to be predictable.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policies A04, E04 and FDJJ 1919 address searches and the type of searches to be conducted. Cross-gender strip and pat-down searches and cross-gender visual body cavity searches are prohibited at the facility. An incident report must be completed if any type of the aforementioned searches occur. All direct care staff members and residents interviewed and the Program Director stated cross-gender searches are not conducted. All staff related the practice of opposite gender searches is prohibited.

Training on the searches of transgender and intersex youth is documented and confirmed by a review of signed training rosters; review of training materials; review of staff meeting agenda; and interviews with direct care staff members. The facility reports no type of cross-gender searches have been conducted at the facility during this audit period. The general searches conducted at the facility are documented by staff, per policy. The policies prohibit staff from searching or physically examining a transgender or intersex youth for the sole purpose of determining the resident's genital status; this information was also verified through random staff interviews. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner.

Shower procedures are outlined in policy A04 and they were explained during the facility tour by the Program Director. The procedures and the configuration of the bathroom/shower area support residents are able to shower, change clothes and perform bodily functions without being viewed by staff. Staff members are aware that the policy provides for transgender or intersex youth to have the opportunity to shower separately.

Policy A04 and posted signs inform opposite gender staff that they must announce themselves upon entering the housing unit. One sign is posted outside of the housing building and another sign is posted inside the building. According to staff and resident interviews, the opposite gender staff verbally announce their presence when entering the housing building. This practice was also observed during the comprehensive tour of the facility.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses the provision of support services for disabled residents. The facility has arrangements with various resources for interpreters and other support services, including services for the hearing impaired, intellectual disabilities, and based on the individual need of the resident. Additional resources available to the facility include the staff from education and mental health services staff. All staff receive the online training course, "Provider Support to the Deaf and Hard-of-Hearing." Assistance may also be provided by Aspire Health Partners' Central \Office staff in securing services for residents who are deaf or hard of hearing. Residents are not used as interpreters as determined from a review of policy and interviews with direct care staff members.

The facility has a list of agencies and their contact information that will provide the support services to residents upon request. The policy provides residents with disabilities and who are limited English proficient be provided with the support services to enable residents to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment.

The facility reports during the past 12 months there has not been a need for interpreters. The random staff interviews support the facility does not rely on resident interpreters, resident readers or any type of resident assistants for the provision of PREA information for another resident as required by policy. The Youth Handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also posted throughout the administrative and housing buildings.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04, FDJJ 1800 and FDJJ 1919 address hiring and promotion processes and decisions. A review of the policies and interview with the Human Resources (HR) Records Specialist collectively provided details regarding the hiring process, completion of background checks, and the grounds for termination of staff. The policies are aligned with the requirements of the standard and requires background checks prior to employment and promotions and every five years. A review of a sample of personnel files with the HR Records Specialist and the interview confirmed the practices.

The hiring process seeks information from applicants regarding previously related sexual misconduct allegations and convictions as provided by policy A04 and as explained by the HR Records Specialist. It is prohibited by facility and FDJJ policies to hire, promote or engage for contract services anyone who may have contact with residents who has engaged in previous sexual misconduct. The interview confirmed the facility considers any incident of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee.

Policies A04, FDJJ 1800 and FDJJ 1919 and the interview with the HR Records Specialist collectively provide staff has a continuing duty to report related misconduct. The system is such that if a staff member gets arrested, personnel will be electronically notified. The policies support omissions of such conduct or providing false information will be grounds for termination.

Standard 115.318 Upgrades to facilities and technologies

☐ 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The standard is not applicable. This is not a new facility, there has not been a substantial expansion or modification to the facility, and the camera system has not been updated since the last PREA audit in 2014.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 address this standard. The facility is not responsible for conducting administrative or criminal investigations. The policies state the Florida Department of Juvenile Justice, Office of 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 Cocoa Police Department will conduct investigations that are criminal in nature.

Written FDJJ Directives 3-05 and 4-03 for the OIG respectively address training and the investigative procedures for its Investigators; and notification to a law enforcement entity when it is believed the investigation is criminal in nature. The Program Director will serve as the contact person with the Cocoa Police Department regarding an investigation. The FDJJ provides each facility written information regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011 to be shared with their local law enforcement agency.

The facility has provided for victim advocacy services through a Memorandum of Understanding (MOU) with Sexual Assault Victim Services (SAVS). Victim assistance to be provided includes guidance through the criminal justice system; access to SAVS' hotline number; crisis intervention and supportive counseling; information and referral; and other individualized services as needed. The MOU references the confidentiality of services. A telephone interview with a representative from the SAVS confirmed the access to victim services for facilities in the area, including accompaniment through the forensic medical examination. A qualified medical practitioner will conduct forensic medical examinations at the local hospital. Treatment services provided to a victim will be free of charge to the victim. There have been no 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)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 require allegations of sexual abuse and sexual harassment to be investigated and identify the investigative entities responsible for conducting investigations. Administrative investigations will be conducted by OIG trained Investigators and sexual abuse allegations are referred for an investigation to the Cocoa Police Department and the Departmen of Children and Families is contacted. The policies instruct staff to cooperate with the investigations. Interviews conducted with the Program Director and the direct care staff members support the policies.

During the past 12 months there were no allegations of sexual abuse or sexual harassment. The policies guide staff to report all allegations of sexual abuse and sexual harassment and to document the reports. Staff members are aware of the policy requirements as verified through their interviews. The FDJJ website provides the information and policy for reporting allegations of sexual abuse and sexual harassment. Reporting information is also posted in various areas of the facility, accessible to resident, employees, contractors, volunteers, and visitors.

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)

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Facility Policy A04 and FDJJ 1919 address PREA related training for staff. A review of policies, training materials, training rosters, training acknowledgement statements; and various staff interviews document staff training occurs as required and refresher courses are conducted periodically and as needed. All staff interviewed were familiar with the PREA information regarding the primary components of prevention, detection and response to sexual abuse or sexual harassment. The facility houses males and the training considers the needs of the population served.

All direct care staffs interviewed supported general topics listed below are included in the PREA training:
*Facility zero-tolerance and PREA related policies;
*Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;
*Resident's right to be free from sexual abuse and sexual harassment;
*The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;
*Dynamics of sexual abuse and sexual harassment in juvenile facilities;
*Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;
*How to avoid inappropriate relationships with residents;
*Common reactions of sexual abuse and sexual harassment juvenile victims;
*Effective and professional communication with all youth admitted to the facility;
*Mandatory reporting; and,
*Relevant laws regarding the applicable age of consent.

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)

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Facility Policy A04 and FDJJ 1919 require volunteers and contractors be trained and made aware of their responsibilities regarding PREA. The review of the zero-tolerance policy is included in the training provided. The PREA training also informs the contractors and volunteers of their role in reporting allegations of sexual abuse or sexual harassment.

Contractors, volunteers and interns are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractor, volunteer or intern. Training acknowledgement statements were reviewed and interviews with a volunteer and a contractor confirmed the training occurs and both confirmed their understanding of the training.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 requires all residents admitted to the facility receive information about the facility's zero-tolerance policy, how to report allegations of sexual abuse or sexual harassment, and the right to be free from retaliation for reporting. The Youth Handbook provides information to residents on how to report any complaint within the facility and it contains information and the Florida abuse hotline number for reporting any form of abuse or neglect. The Youth Handbook is laminated and posted in the dining/multi-purpose room along with additional reporting information and an array of zero-tolerance posters. Reporting information and posters are posted in various areas of the buildings.

The Case Manager who conducts PREA education with residents explained the process for ensuring that residents receive the required information. The residents receive information about their PREA related rights on the same day of admission as verified by the resident interviews and the document review.The PREA related information is a part of the intake packet completed with each resident and residents sign an acknowledgement form verifying the education session. The PREA education was reviewed, including brochures where the material is presented in an age-appropriate manner. Interviews with the Case Manager and residents and a review of documents confirmed the PREA education sessions occur. The PREA related information is provided to staff in policies, training and staff meetings.

The facility has made prior arrangements to provide the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. A contact list for the various companies which provide support services to the facility and a contract for services were reviewed. Prior arrangements have been made for deaf, hard of hearing, and language interpreters; and for document translation. Facility and other Aspire Health Partners staff may also provide support services to residents as needed to enure access to services that will provide disabled residents the opportunity to participate in PREA education sessions. Staff interviews confirmed residents are not used as translators or readers for other residents. The facility reports 42 residents, admitted in the last 12 months, received comprehensive age-appropriate PREA education.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 address this standard. The policies and staff interviews provide the facility staff members do not conduct investigations. Administrative investigations are conducted by the OIG and criminal investigations are conducted by the Cocoa Police Department. Allegations of child abuse are also reported to the Florida Department of Children and Families. The FDJJ agency policy and Directive 3-05 provide that OIG Investigators be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports and in conducting allegations in the FDJJ settings. The Program Director serves as the primary contact for the investigative entity regarding sexual abuse investigations.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy A04 provides medical and mental health staff members receive the regular PREA training and the specialized training available online through the SkillPro training system provided by FDJJ. The mental health and medical staff completed the general training provided for all staff members which is also available through the SkillPro training system. Forensic medical examinations will not be conducted by the facility medical staff. A review of the training records and interviews with medical and mental health staffs revealed their completion of the specialized training.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 outline the process of screening for risk of victimization and abusiveness for all residents and the information to be obtained regarding the resident. Staff and resident interviews and a review of documentation confirmed residents are properly screened. This vulnerability screening occurs upon admission, as stated by residents, and whether the youth is transferred from another facility or is a new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). Other assessment instruments are also used to assess the individual needs of the residents.

The VSAB is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; the youth's self-identification; current charges; offense history; and intellectual or developmental disabilities. Resident interviews, review of a sample of VSABs and the interview with the Case Manager indicated the VSAB is administered according to policies and on the first day of admission to the facility. The facility reports 42 residents admitted to the facility within the past 12 months received the VSAB screening.

According to the Case Manager, the information through the administration of the VSAB is obtained through asking questions and probing where needed; talking to parent/guardian; and reviewing the Electronic Commitment Packet which may be received prior to the youth's arrival to the facility. Policy A-04 states and the Case Manager reports reassessments are conducted every 30 days and the Case Managere adds, or when a resident returns to the facility from a home pass. A review of a sample of VSABs and interviews with over half of the sample of residents revealed the reassessments occur. The information from the risk screening is accessible to treatment staffs and Program Director. The files were observed to be maintained in a confidential manner.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 address this standard and provide guidance to staff regarding the information from the VSAB and outline how the information is to be used. The information obtained through the administration of the VSAB assists in determining bed and other program assignments with the goal of keeping all residents safe and meeting needs of each resident. Isolation is not used in this facility.

Random staff interviews indicates protective measures would be taken immediately if it was determined that a resident was at risk for imminent sexual abuse and responses included separate residents; alert supervisor and/or Program Director; provide closer monitoring; and let resident shower separately.

The policies support that bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The facility prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. Facility and FDJJ policies and the interview with the Case Manager support housing and program assignments for transgender or intersex residents would be made on a case-by-case basis to ensure the resident's health and safety.

The Case Managaer, Program Director and other staff are aware of the procedures that would be implemented, according to policies, when there are transgender or intersex residents within the facility's population. The resident's concern for his own safety is currently taken into account through responses obtained from the administration of the VSAB and as confirmed through resident interviews.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 address this standard and provide multiple internal ways a resident may report, including how he can privately report: sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to the aforementioned incidents. Residents may report allegations of sexual abuse or sexual harassment by telephone through the Florida abuse hotline. Sexual Assault Victim Services may be contacted through their hotline number for victim services. The Florida abuse hotline is also available to staff for reporting the sexual abuse and sexual harassment of residents.

There are additional internal ways a resident may report, such as completing a complaint form and placing it in the locked complaint box; talk to any staff member; complete a form requesting mental health services and place it in the related locked box; and complete a sick call form and place it in the locked sick call box. A third-party may report allegations in writing, through the FDJJ website or the Florida abuse hotline. Access to writing tools is provided for residents so they are able to complete the forms. Information about reporting allegtions of sexual abuse and sexual harassment is contained in the Youth Handbook and is posted throughout the facility. Resident and staff interviews revealed their awareness of the methods a resident may report allegations. The policies state when a resident is housed solely for civil immigration purposes, the resident will be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security.

Staff and residents are aware of policy and practice regarding accepting reports of allegations of sexual abuse and sexual harassment made verbally, in writing, anonymously, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility and could report abuse to that person if needed. The residents were aware third-party reports could be made and reports could be made anonymously. Policies and staff interviews support staff members are required to immediately document all verbal reports. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, staff meetings, and posted information.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy FDJJ 1919, resident PREA education sessions, and the Youth Handbook support a completed complaint form alleging sexual abuse or sexual harassment may be placed in the locked complaint box in the housing building. The resident is not required to handle an emergency complaint informally by attempting to directly resolve the situation with a staff member. When a complaint is received alleging sexual abuse or sexual harassment, the policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policies. The resident and staff interviews confirmed their awareness of how a resident may report an allegation of abuse through the complaint process. During the past 12 months, there has not been a complaint submitted alleging sexual abuse or sexual harassment.

The complaint system does not include a process for facility staff to investigate or resolve allegations of sexual abuse or sexual harassment. The complaint is reported and an investigation may be conducted by the FDJJ Office of Inspector General, Florida Department of Children and Families, or Cocoa Police Department when the allegation is criminal in

nature. The purpose of the resident's submission of a PREA related complaint provides residents and staff another method for ensuring the reporting of allegations and provides management staff with the opportunity to protect the resident. There is no time limit for a resident to submit an emergency complaint alleging sexual abuse or sexual harassment.

Policies A04 and FDJJ 1919 provide a resident may not be charged or disciplined when it has been determined that a report alleging sexual abuse was made in good faith even if an investigation does not result in substantiation of the allegation. Residents understand they will not be punished if a report is made in good faith, as determined through the interviews. The residents have access to complaint forms, writing materials, and locked complaint boxes for depositing the completed form, as determined through observations during the comprehensive tour and interviews with residents and staff. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses the residents' access to outside confidential victim support services. The facility has a Memorandum of Understanding (MOU) with Sexual Assault Victim Services (SAVS) for the provision of advocacy seravices including but are not limited to supportive counseling, access to a 24-hour hotline and other advocacy services. Contact information for SAVS is posted in the facility, accessible to residents and staff. The MOU lists the responsibilities of the facility and the responsibilities of SAVS. During the comprehensive tour of the facility the posted information; complaint, mental health request and sick call forms; and locked boxes for the completed forms were observed. The interviews with the Program Director and SAVS representative; review of the MOU and policy; and observation of posted information confirmed victim advocacy services have been arranged.

All resident interviews and the interview with the Program Director; Youth Handbook; policy; and observations during the facility tour support residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents/legal guardian. All residents were aware of how they could communicate with their parents/legal guardian and attorneys and court workers could visit the facility. Residents also confirmed they had someone on the outside to report allegations of sexual abuse if they needed to. The residents interviewed were aware of the days and times for visitation and use of the telephone.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 addresss third-party reporting and interviews revealed residents are aware that third-party reporting of sexual abuse or sexual harassment can be done. All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse. Staff interviews revealed their knowledge of third-party reporting and they can receive allegations from third parties. Information regarding reporting is provided through observed postings located in areas of the facility accessible to visitors, residents and staff members. The FDJJ website contains information regarding third-party reporting of allegations of sexual abuse.

Interviews with random staff revealed they are aware of their obligation to receive and submit reported allegations from others. It was revealed staff may privately report allegations of sexual abuse through the FDJJ website, abuse hotline or go directly to the Program Director or other management staff. It was also revealed through interviews staff members are aware they are to document all verbal reports. Interviews with residents confirmed their knowledge of what third-party reporting means. The residents shared the methods within the facility in which residents may make third-party reports such as the complaint process, talking to staff, and utilizing the Florida abuse reporting hotline.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses the standard and require all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation. Staff members are prohibited from revealing any related information to anyone other than those who are involved in treatment, investigation and other security and management decisions.

Staff members are instructed to immediately report all allegations to their immediate supervisor and the supervisors are to ensure the direct report of the allegation to the FDJJ Central Communications Center. The policy requires management staff to notify the alleged victim's parents or legal guardians. If the resident is under Department of Children and Families (DCF) custody, the DCF Case Worker will be notified and if applicable, the attorney of record will be notified of the allegation within 14 days of receipt of the allegation, according to the Policy.

Interviews with direct care, mental health and medical staffs and the Program Director revealed they are aware of the requirements regarding their reporting duties and understand they are mandated reporters and must immediately report all allegations of sexual abuse and complete a written follow-up report. All direct care staff members interviewed provided information aligned with the reporting requirements and the expectation is reports are documented as soon as possible.

The facility staff members are also required by policy to report allegations made anonymously or by a third-party. According to interviews with the Clinical Manager and Nurse, the residents are informed at the initiation of services of the limitations of confidentiality and their duty to report and implement signed informed consent where applicable.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 requires staff to protect residents by immediately implementing protective measures when the resident is subject to substantial risk of imminent sexual abuse. The summarized interviews of the random staff and the Program Director revealed protective measures should be implemented immediately and included but not limited to: alerting supervisor and/or management staff; separating the alleged victim from the alleged perpetrator; closer monitoring of the resident by staff; and documenting the situation.

Residents indicated during the intake process, their feelings about their own safety is part of the inquiries by staff and are explored periodically by the Case Manager and other treatment staff. The facility reports during the past 12 months, no residents were identified as being 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)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 require the Program Director, upon receiving an allegation a resident was sexually abused while confined at another facility, must notify the head of the facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The Program Director must also notify the FDJJ Central Communications Center to report the incident. The policies also require notification to the facility head where the alleged incident occurred and the apprppriate investigative agency.

The facility reports there has not been a report about an incident of sexual abuse occurring while the resident was confined in another facility during the past 12 months. The Program Director is aware of the procedures and his duties regarding reporting to other confinement facilities and the requirement allegations received from other facilities must be investigated.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 outlines the staff first responder duties and summarily requires any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. A September 9, 2014 Interoffice Memorandum from the FDJJ Inspector General is still in effect for employees and contract providers. The memorandum reminds employees and contractors to follow FDJJ 1919 in the event of a suspected sexual abuse incident to protect the evidence.

Interviews with staff members who would serve as first responders and a non-security staff revealed they are aware of their duties if a sexual abuse incident occurs. A non-security staff who may act as a first responder is expected to request physical evidence be preserved and to contact direct care staff for assistance. During this audit period there was not an incident or allegation of sexual abuse.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a written document, Coordinated Response, which details the actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staffs. This Coordinated Response to an incident of sexual abuse is also aligned with Policies A04 and FDJJ 1919. The interviews with direct care, mental health and medical staff members revealed their familiarity with their role regarding the response to an allegation of sexual abuse, aligned with the policies and the written Coordinated Response.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 provide protection to residents and staff from retaliation because they reported an allegation of sexual abuse or cooperated with an investigation. The retaliation monitor has been identified as the Program/Training Manager. An interview revealed he understands 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. He also discussed some of the factors considered in detecting retaliation, such as housing and program changes and interactions.

The Program Director also revealed he would initiate the contact with the resident who reported the allegation of sexual abuse and make periodic status checks with residents and/or staff, as required. The FDJJ 1919 policy provides retaliation monitoring would be for at least 90 days. The Program/Training Manager revealed through the interview the retaliation, in practice, would be for 90 days and continuous where indicated.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A-04 and FDJJ 1919 address this standard and staff interviews revealed administrative investigations are conducted by the FDJJ Office of Inspector General and criminal investigations are conducted the Cocoa Police Department. Sustained allegations as a result of a criminal investigation will be referred for prosecution. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse.

The policies direct facility staff to cooperate with investigations. The FDJJ 1919 policy states an investigation is not terminated because the source recants the allegation. The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings and the Investigators receive training on the related agency policies.

Standard 115.372 Evidentiary standard 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility PolicyA04 and FDJJ 1919 require the victim or victim's parents/legal guardians be informed when the investigation is completed and of the outcome of the investigation. Written notification will be made regarding the completion of the investigation and will include the identification of the investigative entity and state the findings.

The policies support following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been indicted, charged, or convicted. The Program Director is familiar with the policies and will remain abreast of an investigation conducted by the investigative entities by serving as the primary contact person.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 provide for disciplinary sanctions, up to and including termination for those staff who violate the facility's sexual abuse and sexual harassment zero-tolerance and related policies. Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment will be appropriate to the circumstances of the incident, the staff member's disciplinary history, and the sanctions for similar cases of other staff. Policy A04 requires termination shall be the presumptive disciplinary sanction for staff who engaged in sexual abuse.

The facility reports during this audit period, no staff member was disciplined for violation of sexual abuse or sexual harassment policies or reported to law enforcement by the facility for violating such policies. The policies provide for terminations or resignations by staff who would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. The interviews with the Human Resources Records Specialist from the Aspire Health Partners' Central Office and the Program Director revealed the agency's personnel practices and their knowledge of the related policies.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 and FDJJ 1919 address this standard, including requiring 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 and to relevant licensing bodies. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

A review of training acknowledgement statements, training materials and interviews with a contractor and volunteer revealed the facility takes measures to provide volunteers and contractors a clear understanding sexual misconduct with a resident is strictly prohibited and is a serious breach of conduct. The interviews confirmed participation in PREA training and awareness of the zero-tolerance policy and how to report allegations of sexual abuse or sexual harassment of residents.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ Policy 1919 and the Youth Handbook address this standard including an administrative process for dealing with violations, including resident-on-resident sexual abuse. The policy, Youth Handbook and staff interviews support the formal process and the behavior management system promote positive social change while holding the residents accountable for their actions. A resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse, according to the Program Director. Sexual activity between residents is prohibited and court or administrative processes and sanctions occur after determination the sexual activity was coerced. Residents would be disciplined for sexual contact with staff only when it has been determined the staff member did not consent to the sexual contact. Isolation is not used in this facility.

Policies A04 and FDJJ 1919 provide anyone reporting in good faith will not receive any repercussions. The policies and interview with the Clinical Manager supports counseling or other interventions will be offered to address and correct the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after a sexual abuse incident. The interview with the Clinical Manager also revealed any type interventions or treatment services provided are not as a condition for the resident to access participation in the behavior management system, education services, or other programs. An offending resident would be offered services while in facility; however, the resident would be subsequently transferred to a more appropriate placement.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses this standard, including providing for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with the Nurse, Clinical Manager and Case Manager; review of documentation; and observations during the comprehensive facility tour confirmed the practice of residents being promptly seen by specialized staff. Residents are generally seen by medical and mental health staff on the same day of admission as part of the intake process. Policy supports information related to sexual victimization or abusiveness which occurred in an institutional setting is limited to those staff where it is based on their need to know to make the appropriate management and security decisions.

The interviews with the Nurse and Clinical Manager and observations revealed medical and mental health staff members maintain documentation of the services they provide to each resident. Medical and mental health staff discussed their knowledge of informed consent, in accordance with policy. The facility utilizes a consent form regarding treatment services. The age range of residents admitted to the facility is 12-15 years old.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04; staff interviews; and a review of documented practices revealed emergency medical care and crisis intervention services will be provided by medical and mental health staffs as required. Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate. Observations revealed medical and mental health staff members maintain secondary materials that document services to residents and these staff are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policies and understood by the medical and mental health staff treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation.

The interviews with the Nurse and the Clinical Manager revealed residents have unimpeded access to emergency services. Posted sick call and mental health request forms and related locked boxes were observed in the housing building during the facility tour. The Clinical Manager and Nurse shared that medical and mental health services are determined according to the professional judgment of the practitioner.

Policies/procedures and the coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. Staff interviews confirmed their awareness of the policies and the methods to implement for protecting residents. The interviews with the Nurse and the Clinical Manager confirmed timely information would be provided to a victim regarding sexually transmitted infection prophylaxis.

It was determined through the interviews with medical and mental health staff; interviews with other staff and residents; review of the written response plan and other documentation; and observations that immediate medical treatment and crisis intervention services will be provided to an alleged victim of sexual abuse.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses this standard. Interviews with the Nurse and Clinical Manager confirmed on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. The interviews supported on-going services would include follow-up medical and mental health services and referrals as needed. The Nurse confirmed resident victims will be offered tests for sexually transmitted infections as medically appropriate. The Memorandum of Understanding with the victim advocacy agency also provides for referral services. All treatment services will be provided at no cost to the victim.

Policy A04; staff interviews; document review; and observations revealed medical and mental health services are consistent with the community level of care. The policy, interviews and document review also support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or a juvenile facility. The policy provides for a mental health practitioner to conduct a mental health evaluation within 60 days on a resident who discloses youth-on-youth abuse. The Clinical Manager stated all residents receive a mental health evaluation, which are generally completed within two days of admission to 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)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Policy A04 addresses this standard and provides for an incident review to be conducted within 30 days of the completion of an investigation in accordance with the standard. The policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The policy also identifies the positions which comprise the team. The Program Director and the Program/Training Manager, who will serve as a member of the incident review team, are knowledgeable of the purpose of the incident review process and what it involves.

During this audit period, there were no allegations of sexual abuse. A dedicated form will be used to record the events of an incident review team meeting when one is required. The form allows for the assessment of the incident and inclusion of recommendations. The incident review team will be facilitated by the FDJJ statewide PREA Coordinator.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies FDJJ 1919 and FDJJ 2020 address this standard. Data collection is the primary responsibility of FDJJ. A review of reports confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contract providers, using a standardized instrument and specific guidelines.

The format used for FDJJ facilities and contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ). Florida DJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with directives by FDJJ and FDJJ aggregates the sexual abuse data which culminates into an annual report. The FDJJ provides DOJ with PREA related 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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

The annual report is approved as required. The report demonstrates that the agency has compared the results of annual reports and used them to continuously improve policies; procedures; practices; and training on a statewide basis. Through the data review for corrective action, the FDJJ has continuously updated policies and enhanced training and other processes. The annual report for FDJJ and the facilities under its control has been reviewed and the report is accessible to the public through the FDJJ website. There are no personal identifiers on the annual reports.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 provide all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless statutes require otherwise. According to the policy, the aggregated sexual abuse data from all facilities will be readily available to the public through the FDJJ website; the practice is the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers, as required.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Shirley L. Turner — September 6, 2017

Auditor Signature — Date