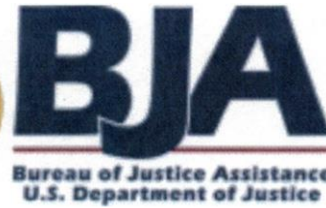
REA AUDIT: AUDITOR'S SUMMARY REPORT

JUVENILE FACILITIES



Name of Facility: Eckerd Youth Challenge Program

Physical Address: 201 Culbreath Road, Brooksville, FL 34609

Date report submitted: May 10, 2015

Auditor information: Shirley L. Turner

Address: 3199 Kings Bay Circle, Decatur, GA 30034

Email: shirleyturner3199@comcast.net

Telephone number: 678-895-2829

Date of facility visit: April 13-14, 2015

Facility Information

Facility Mailing Address: 201 Culbreath Road, Brooksville, FL 34609

Telephone Number: (352) 799-5621

The Facility is:	☐ Military	☐ County	☐ Federal
	☐ Private for profit	☐ Municipal	☐ State
	☒ Private not for profit		
Facility Type:	☐ Detention	☐ Correction	☒ Other: Residential

Name of PREA Compliance Manager: J. Patrick Girdner	**Title:**	Senior Director
Email Address: pgirdner@eckerd.org	**Telephone Number:**	(727) 482-7513

Agency Information

Name of Agency: Eckerd, Inc.

Governing Authority or Parent Agency: NA

Physical Address of Agency: 100 N. Starcrest Dr., Clearwater, FL 33765

Mailing Address: Same as Above

Telephone Number: (727) 461-1236

Agency Chief Executive Officer

Name: David Dennis	**Title:**	Chief Executive Officer
Email Address: ddennis@eckerd.org	**Telephone Number:**	(727) 461-2990

Agency Wide PREA Coordinator

Name: Elaine Woods	**Title:**	Director of Quality
Email Address: ewoods@eckerd.org	**Telephone Number:**	(727) 424-3601

AUDIT FINDINGS

NARRATIVE:

The Eckerd Youth Challenge Program, located in Brooksville, Florida, is a 60-bed residential facility that houses low and moderate risk male juvenile offenders in the age range of 14-19. The facility is operated by Eckerd, Incorporated through a contract with the Florida Department of Juvenile Justice (FDJJ). Program services include Mental Health Overlay Services and Substance Abuse Overlay Services; the average length of stay is seven months. At least 103 residents have been admitted to the facility in the past 12 months. The average length of stay is seven months.

On-site medical services are provided by a full-time Registered Nurse; part-time Licensed Practical Nurse; and a contract physician who visits the facility once a week. Mental health services are provided on-site under the supervision of the Clinical Services Coordinator with the unit consisting of Therapists, Case Managers, and a Program Specialist. The contract psychiatrist visits the facility twice a month. The facility offers education and vocational services on-site, where credits may be earned at the end of each semester for the course work completed within the school program. Direct care staff provides direct supervision to residents as they move to and engage in activities throughout the program.

Parents and legal guardians are encouraged to be involved in the resident’s treatment plan. Additionally, contact between the parents/legal guardians and the residents is encouraged and facilitated through letter writing; program visits; support groups; phone calls; teleconferences for treatment meetings when parents cannot attend on-site; and home visits. Family workshops are conducted at the facility each month where the resident and parent participate in the training together. After the workshop, each parent may have lunch on-site with their child.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is located on vast acreage in a wooded area consisting of 13 buildings. The administration building contains the entrance foyer and front desk; administrative offices; conference room; medical clinic area; kitchen; and a large dining area. There are six dormitories that house 10 residents each. The dormitories have bathrooms that provide residents a reasonable amount of privacy while they shower, change clothes and perform bodily functions. Each dormitory also has a laundry room. Attractive murals accentuate the walls in the dormitories and each one has a telephone and access for emergency telephone calls. There are four education buildings that contain a total of seven classrooms, including a computer lab.

There is ample space on the outside grounds for the storage buildings and the grounds can accommodate an array of recreation and other activities. Included on the grounds are a volleyball court, basketball court, four separate playing fields, and a gazebo. Reportedly, the program utilizes 50-60 acres of the property. At least 55 employees, who may have contact with residents, are employed at the facility.

SUMMARY OF AUDIT FINDINGS:

An initial conference call was held with facility staff, FDJJ PREA Coordinator and the Auditor to review the on-site audit process and data gathering. The notifications of the on-site audit were posted in various parts of the facility at least six weeks prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to the Auditor, noting their locations. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. After reviewing the information on the flash drive, follow-up conversations were held with facility staff. Additional information was provided or clarified as requested. The Senior Director serves as the PREA Compliance Manager.

The on-site audit was conducted April 13-14, 2015. An entrance meeting was held with the Senior Director, Program Director, and Education Administrator. After the meeting a comprehensive tour of the facility was conducted by the Senior Director and the Program Director. During the tour, staff members were observed to be directly supervising the residents. There were two staff from the corporate office present at the facility on the first day of the audit, including the Director of Quality who also serves as the PREA Coordinator for the agency. Random staff, specialized staff and residents were interviewed during the on-site audit process. While on-site, additional information was provided as needed and in a prompt manner. A close-out meeting was held at the conclusion of the audit and a summary of the audit findings was provided.

Number of Standards Exceeded: 0

Number of Standards Met: 37

Number of Standards Not Met: 0

Number of Standards Not Applicable: 4

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The facility has a primary Policy, 6.0, and supporting policies that provide guidelines for implementing the agency's approach to complying with the requirements of the PREA standards. Policy 6.0 provides a zero-tolerance approach toward all forms of sexual abuse and sexual harassment. The Policy contains definitions of the prohibited behaviors and addresses sanctions for those who participate in such behaviors. The Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919) is also used and adhered to in complying with the PREA standards.

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

Auditor Comments:

The facility does not contract with other facilities for the confinement of their residents.

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 provides for a staffing plan to protect residents against sexual abuse. The documented staffing plan ratios are aligned with the current program contract which will be reviewed in October 2015. The facility reported no deviations from the current staffing plan in the past 12 months. The annual assessment of the staffing plan and other areas has been conducted to determine whether adjustments are needed in accordance with the standard. A review of the staffing has been documented through the completion of the Staffing Plan Assessment form.

Unannounced rounds for the maintenance of a safe environment are conducted and documented by appropriate staff. Interviews and a review of documentation confirmed the practice of unannounced rounds. Policy 6.0 prohibits staff from alerting other staff that the unannounced rounds are occurring and that sanctions shall be applied if this occurs.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 5.05-5.06, 6.0 and the Training Guide address this standard. Policy 6.0 prohibits cross gender pat-down and strip searches, except in exigent circumstances; there have been no cross gender searches during this audit period. Policy 6.0 and FDJJ 1919 have been implemented that provide for residents to shower, perform bodily functions, and change clothing without being observed by non-medical opposite gender staff. Interviews with staff and residents confirm the practices. Policy 6.0 states that staff shall not search a transgender or intersex resident to determine 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)

Auditor Comments:

Policy 6.0 addresses that support will be provided to residents with disabilities and residents who are limited English proficient so that they may benefit from and participate in PREA education. Resident education materials are available in dominant languages other than English and the facility has access to interpreters through Language Line Services. Support and resources are also available through the education unit.

Policy 6.0 ensures that the facility will not rely on resident interpreters or resident readers. A review of documentation and staff interviews confirmed that outside resources would be used to assist residents. The facility has a form, PREA Communication for Youth with Disabilities or Limited English Proficiency, which will be used to document the resident's required accommodations and note the accommodations that were provided.

Standard 115.317 Hiring and Promotion Decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 address this standard and provides for background checks on all employees and contractors through a process that is aligned with the standard and is a statewide requirement of FDJJ. Prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

X Standard Not Applicable

Auditor Comments:

This standard is not applicable; the facility does not have a camera monitoring system.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 address this standard and in addition to the other requirements, state that forensic medical examinations will be completed at no financial cost to the victim. Additionally, the Policies direct staff to cooperate with investigations. The facility has a Memorandum of Understanding (MOU) with the Dawn House of Hernando County which provides victim advocacy services that include but are not limited to accompaniment to forensic examinations, counseling, crisis hotline, and training for staff and residents. There have been no forensic examinations conducted during this audit period.

E-mail correspondence exist showing that the Hernando County Sheriff's Department has received from the facility the guidelines regarding PREA related investigations. The representative from the Sheriff's Department confirms their knowledge of the procedures.

Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0, FDJJ 1919 and staff interviews provide for staff reporting all allegations of sexual abuse and sexual harassment. The appropriate investigative entity will be contacted regarding allegations of sexual abuse or sexual harassment. There has not been an allegation reported during this audit period. The abuse hotline number is on the agency's web page for the facility. The FDJJ website contains information regarding the referral of allegations for investigations of sexual abuse. The facility posts related information in areas accessible to the public.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 provide for the PREA training of all staff. The facility staff received the FDJJ training and in-house training in the key areas referenced in the standard. Documentation of staff participating in training is maintained and staff interviews reflected that PREA training has occurred.

Standard 115.332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 contain information regarding the training of volunteers and contractors who have contact with residents. Receipt of the training is documented and it contains a review of the agency's zero-tolerance policy.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Resident education is addressed in Policies 1.03-1.04 and 6.0. Documentation and interviews with residents and staff confirmed that residents participate in PREA education sessions. Documentation of a residents' participation in these sessions is maintained on an Orientation Checklist. Through reviewed resources, interviews and based on Policy 6.0, the facility will provide support services in accessible formats for residents who are limited English proficient; deaf; visually impaired; or otherwise disabled.

Standard 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:
FDJJ 1919 provides that investigators are trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Training is provided to investigative staff regarding conducting investigations in the FDJJ settings.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:
Policy 6.0 and FDJJ 1919 address PREA training for medical and mental health staff. A review of documentation and staff interviews confirmed their training. The full-time Registered Nurse has also received additional training in Evidence Collection and Preservation in a Healthcare Setting through a continuing education course. The facility nurses do not conduct forensic medical examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:
Policies 6.0 and 3.04 address this standard. A review of documentation and staff and resident interviews confirmed that screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being conducted on each resident. The initial screening is done during the intake process and Policy 3.04 provides guidance for reassessments to be conducted.

Standard 115.342 Use of Screening Information

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:
Policy 6.0 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. The Policy provides that housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. Additionally, the facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

An Initial Risk/Crisis Assessment Plan is also completed on each resident, considering numerous factors including the score from the screening instrument used to determine the risk of sexual abuse victimization or sexual abusiveness toward other residents. Isolation is not used at this facility.

Standard 115.351 Resident Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policy 6.0 and staff and resident interviews, there are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that lead to abuse. A resident may complete a grievance form; complete a Youth Communication Request form where a resident seeks to talk to specific staff; talk to any staff member; and third parties may report allegations.

PREA related information is posted in each dormitory and in other areas of the facility. Residents are provided access to a telephone in each dormitory to report allegations of sexual abuse and sexual harassment. The abuse hotline number is also accessible from any office phone in the administration building. Interviews revealed that staff members are aware of their responsibility to report sexual abuse and sexual harassment. They are also aware that they are to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties in accordance with Policies 6.0 and FDJJ 1919.

Standard 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 6.0 and 2.27-2.29 address the grievance process and information is provided to the residents in the Student Handbook. Residents may put a completed grievance form in the locked grievance box. Residents are not required to attempt resolution to a grievance alleging sexual abuse or sexual harassment. The facility reports that there have been no grievances submitted relating to sexual abuse or sexual harassment during this audit period. Reporting procedures will be implemented when a grievance is received alleging 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 Comments:

Policy 6.0 requires the facility to provide the residents with access to outside victim advocacy services. The documented MOU provides for services that will be delivered by the Dawn Center of Hernando County, a rape crisis center. A telephone conversation with the Executive Director confirmed that victim services will be provided to the facility when requested and that no services have been requested.

Residents are allowed to see their parents at visitation on the weekends and they are also allowed to make weekly phone calls. An additional phone call may be earned through the behavior management system. Attorneys or other legal representation may visit the facility and may visit in a confidential manner.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 addresses third-party reporting. The DJJ website provides the public with information regarding third-party reporting of abuse. Parents receive information about reporting incidents of sexual abuse through information posted in the facility, accessible to the public. The facility's agency website has the abuse reporting hotline number posted. Staff and resident interviews supported that allegations may be received by third parties.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 addresses this standard. Staff members are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse or sexual harassment; retaliation against residents or staff who report any incidents; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff interviews supported the Policy.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 addresses this standard and provides that when the facility staff learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to

protect the resident. Staff interviews supported the Policy. There have been no incidents during this audit period where the facility took any action in regards to a resident being in 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 Comments:

According to Policy 6.0 and interview, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Senior Director or his designee will notify the head of the facility where the alleged incident occurred within 72 hours. The Senior Director /designee will also contact the appropriate investigative agency, according to facility and FDJJ policies.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 addresses the first responder duties and provides an account of duties and responses. There has not been an allegation by a resident regarding sexual abuse during this audit period. Staff interviews reflected staff members' knowledge of the first responder duties.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

A review of the coordinated response plan and interviews with staff confirmed knowledge of the protocols. The plan coordinates the actions to be taken among staff including first responders, leadership, and medical and mental health staffs in response to an incident of sexual abuse.

Standard 115.366 Preservation of Ability to Protect Residents from Contact with Abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

Auditor Comments:

This standard is not applicable; the facility does not maintain any collective bargaining agreements.

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 addresses protection against retaliation for residents and staff who report allegations of sexual abuse or sexual harassment. The Senior Director has been identified as the staff member designated with monitoring for possible retaliation. If the conduct is identified the Policy and interview state that the monitoring is for 90 days and longer if needed.

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)

X Standard Not Applicable

Auditor Comments:

This standard is not applicable; isolation is not used at this facility.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 address this standard. Administrative investigations are conducted by the FDJJ Office of Inspector General (OIG) and criminal investigations are conducted by the Department of Children and Families and local law enforcement. Both Policies direct facility staff to cooperate with the investigations. An investigation is not terminated solely because the source of the investigation recants the allegation and substantiated allegations of conduct that appear to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy FDJJ 1919 supports that a standard of the preponderance of the evidence is used for determining if allegations are substantiated.

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 provide the process for and the details of notifying the victim or victim's parents/legal guardians following the conclusion of an investigation. Notification includes whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded. All such notifications are required to be documented.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 provide for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. The policies require that the violation be reported to local law enforcement, unless the activity was clearly not criminal, and provides for contacting relevant licensing bodies. In the past 12 months, no staff has been terminated or has resigned for violating PREA 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 Comments:

Policy 6.0 and FDJJ 1919 provide that the incident will be reported as required. The policies inform that measures are taken to prohibit future contact with residents in the case of any violation of the facility's PREA related policies by contractors or volunteers. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 provides that any resident found in violation of the facility's zero- tolerance policy against sexual abuse may be subject to disciplinary action, following an administrative finding of resident-on-resident sexual abuse. Policy 6.0 further states that a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact. During the past 12 months there have been no incidents of sexual abuse.

Standard 115.381 Medical and Mental Health Screenings; History of Sexual Abuse

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 3.04 and 4.02 address this standard. Residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed confirmed knowledge and practice of the Policies and the requirements of the standard. The referral summary is documented and a form, PREA Tracking Log, is maintained that also documents the occurrence of follow-up meetings.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 and FDJJ 1919 provide that timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse will be provided. The nature and scope of the services are determined by medical and mental health practitioners according to their professional judgment.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 provides for ongoing medical and mental health care for sexual abuse victims. It also provides for medical and mental health evaluations and appropriate treatment in accordance with the standard. According to staff interviews and a review of documentation, health services are consistent with the community level of care.

Standard 115.386 Sexual Abuse Incident Reviews

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.0 will serve as the guide for staff in conducting sexual abuse incident reviews. The incident review team has been identified in the Policy. Staff interviews indicated that the role of the incident review team is understood. The PREA Sexual Abuse Incident Review form will be used to document the proceedings.

Standard 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 requires the collection of accurate, uniform data for every allegation of sexual assault. The FDJJ has developed a data collection instrument that includes the required data.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 requires the review of data for corrective action towards improving the effectiveness of the agencies' prevention, protection and response policies, practices, and training regarding PREA.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

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

AUDITOR CERTIFICATION:

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

Shirley L. Turner

May 10, 2015

Auditor Signature Date