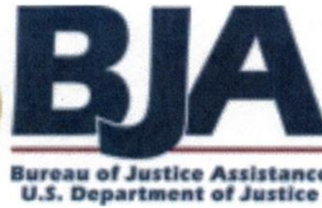
PREA AUDIT: AUDITOR'S SUMMARY REPORT JUVENILE FACILITIES



Name of Facility: Escambia Boys Base			
Physical Address: 640 Roberts Avenue, Pensacola, FL 32511			
Date report submitted: December 20, 2014			
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: November 21, 2014			
Facility Information			
Facility Mailing Address: 640 Roberts Avenue, Pensacola, FL 32511			
Telephone Number: 850-453-7490			
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: William Freeman		**Title:**	**Director of Operations**
Email Address: EBB-DO@amikids.org		**Telephone Number:**	**850-453-7490**
Agency Information			
Name of Agency: AMI Kids Pensacola Escambia Boys Base			
Governing Authority or Parent Agency: AMI Kids, Inc.			
Physical Address: 5915 Benjamin Center, Drive, Tampa, FL 33634			
Mailing Address: Same as Above			
Telephone Number: 813-887-3300			
Agency Chief Executive Officer			
Name: O. B. Stander		**Title:**	**CEO**
Email Address: OBS@amikids.org		**Telephone Number:**	**813-887-3300**
Agency Wide PREA Coordinator			
Name: Wendell Watson		**Title:**	**Regional Director**
Email Address: WLW@amikids.org		**Telephone Number:**	**321-863-1492**

AUDIT FINDINGS

NARRATIVE:

The Escambia Boys Base is located in Pensacola, Florida on an active military installation. It is operated by AMI Kids, Inc. through a contract with the Florida Department of Juvenile Justice (DJJ). The facility is a moderate risk residential treatment facility that serves male juvenile offenders between the ages of 14 and 18. The length of stay is six to nine months and the capacity of the facility is 28. Forty-one residents have been admitted to the facility in the past 12 months.

Medical services are provided on-site by two full-time Registered Nurses and one contract Nurse. The contract physician visits the facility at least weekly. Mental health treatment is provided by the Director of Treatment and two Therapists. The contract psychiatrist visits the facility at least every other week. The Treatment Coordinator also supervises two Case Managers and a Transition Case Manager. Education and vocational services are provided through the Escambia County School District. The education classes include English, Math, Science, Social Studies and one elective course. Vocational services offer pre-employment training, specific job training, and a scholarship program to the technical or community college. GED preparation is also provided for those residents who qualify.

A Performance Plan is developed by the treatment team for each resident. The treatment team consists of case managers and representatives from education, administration, direct care, and mental health staff. A behavior management system exists and includes levels that are accompanied by increasing privileges and rewards at each level. The facility provides recreation activities and community service projects.

The facility is a recipient of the President's Volunteer Service Award, presented by the Corporation for National and Community Service. The Award is in recognition and appreciation of the facility's commitment to making a difference through community volunteer service. The Award was accompanied by a congratulatory letter from President Barack Obama which also stated appreciation for the facility's commitment to the community as shown through service.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There is one main building that houses the program. The front of the building contains administrative offices and a large dayroom space which is divided into two areas. One end of the hall contains offices, two classrooms, and a conference room/computer lab. The other end of the hall contains the residents' rooms and the medical clinic area. The bathroom and the laundry room are located on the housing wing. Residents are provided a reasonable amount of privacy during showers, while using the toilet, and when changing clothes.

The residents eat all meals in the dining hall where the military personnel eat. The grounds behind the facility provide ample space for various outside large muscle exercises, recreation and other activities. The residents also have access to additional outside space behind the facility for planned activities.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility 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 this Auditor, noting their locations. The facility policies and supporting documentation were uploaded to a flash drive, which was received by the Auditor prior to the on-site audit. After reviewing the information, notes were sent to the Executive Director to seek clarity of information and to note the additional documents needed. In response to the issues noted, additional information was provided prior to the on-site audit and discussed during the site visit. Telephone conversations were held with the Executive Director, the Director of Operations who also serves as the PREA Compliance Manager, and the Compliance Specialist to review the PREA audit process and the data gathering.

The on-site audit was conducted November 21, 2014. An entrance meeting was held with the Executive Director. After the meeting a tour of the facility was conducted by one of the residents and included the Compliance Specialist. During the tour, staff members were observed to be interacting with and directly supervising the residents. Random staff, specialized staff and residents were interviewed during the on-site audit process. Interviewed staff and residents confirmed that they had knowledge of the zero tolerance policy against sexual abuse and sexual harassment and how to report allegations. At the conclusion of the audit, a summary of the findings were provided in a close-out meeting with the Executive Director, Director of Operations and the Compliance Specialist.

Number of Standards Exceeded: 0

Number of Standards Met: 38

Number of Standards Not Met: 0

Number of Standards Not Applicable: 3

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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:

The facility has a compilation of PREA policies and procedures that include the all-encompassing Florida Department of Juvenile Justice PREA Policy, 1919 (FDJJ 1919). The policies and procedures provide guidelines for implementing the agency's approach to complying with the requirements of the PREA standards. Policy 6.11 and FDJJ 1919 contain definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. The Director of Operations has been identified as the PREA Compliance Manager for this audit period.

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)

X☐Standard Not Applicable

Auditor Comments:

The facility does not contract with outside agencies for the confinement of residents.

Standard 115.313 Supervision and Monitoring

☐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:

A Staffing Plan Assessment report has been completed showing a review of staffing and other areas. The staffing plan is predicated on a daily census of 28 and the current facility contract. When the required ratios are not met due to limited and discrete exigent circumstances, a hold-over plan is in place that includes identified staff. The unannounced rounds to deter sexual abuse are conducted and documented by the appropriate staff.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.15 prohibits staff from searching a transgender or intersex resident to determine the resident's genital status. The Policy also prohibits cross-gender strip and visual body cavity searches and cross-gender pat-down searches. The viewing of residents by opposite gender staff while they are showering, changing clothes, and performing bodily functions is not permitted, unless there are exigent circumstances. The Policy provides for the staff training in conducting pat-down searches and searches of transgender and intersex residents.

Staff and resident interviews support that there have been no cross-gender pat-down, strip or body cavity searches of residents during this audit period. Staff and resident interviews also confirmed that staff members of the opposite gender announce themselves when entering the housing areas or other areas where residents may be performing bodily functions. On the door leading to the housing area is a sign that reminds opposite gender staff to announce there presence in that area.

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 6.16 state that the facility will not rely on resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services would jeopardize a resident's safety or an investigation. The Policy supports that if the situation occurs where a resident has to be used on an interim basis, the explanation for the use of resident must be documented in the daily shift log. The facility will provide residents with support services through the Escambia County School District and the Health Department.

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:

Policies FDJJ 1919 and FDJJ 1800 provide for background checks on all employees and contractors through a process that is aligned with the standard. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Cameras are used to support the viewing of residents, in addition to direct supervision by staff. There are a total of 16 cameras including inside and outside of the building. There is a plan to add additional cameras. The Executive Director can view various screens from the monitor in his office and identified staff members have the capability to access the camera system from remote locations through their laptop computer.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According Policy 6.21, victim advocacy services will be provided. The facility has a Memorandum of Understanding for advocacy services with the Lakeview Center, Inc., through its Rape Crisis/Trauma Recovery Program. When requested, a qualified staff member from the agency will provide support services including accompanying the victim through the forensic medical examination process. Other services that will be provided by the Lakeview Center include emotional support, a 24/7 rape crisis hotline, and information and referrals.

The provision of services to be provided was confirmed through interviews, including a representative from the Lakeview Center. Forensic medical examinations will be provided at the Baptist Hospital, by qualified medical practitioners. There has not been a need for a forensic medical examination during this audit period.

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

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 6.22 and FDJJ 1919 identify the agencies that will conduct the criminal and administrative investigations. Policy instructs the facility staff to cooperate with the OIG investigations. Facility policy ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. During the past 12 months, there were no allegations of sexual abuse or sexual harassment.

The policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is available to the public on the DJJ website. Information regarding reporting sexual abuse is included in a letter that is a part of the intake package sent to the parent/legal guardian from the facility.

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:

The facility and FDJJ 1919 provide for PREA training for all staff. The staff training covers the key areas referenced in the standard. A review of the training documentation and interviews with staff confirmed that the training is provided.

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 6.32 contains information regarding the training of volunteers and contractors who have contact with residents. According to the Policy, the training is based on the services provided. Receipt of the training is documented.

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:

Policy 6.16 requires that residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. During the intake process residents are provided an education session regarding PREA. Acknowledgement statements, signed by the residents, were reviewed. Residents transferring from another facility will also receive the PREA education during the intake process, according to the Policy and staff interviews. PREA education will be provided through accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled. Support services may be delivered by providers through the Escambia County School District or the Health Department.

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 states that staff in the OIG will be 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 DJJ settings.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐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 addresses this standard. The medical and mental health staff have received the on-line specialized training. 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:

The Screening for Vulnerability to Victimization and Sexually Aggressive Behavior instrument is completed on each resident. Staff and resident interviews, a review of Policy 6.41, and a review of completed instruments confirmed that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being conducted. The Policy also provides for reassessments.

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 6.42 requires that the information gleaned from the screening instrument be considered regarding housing/bed assignment and program assignments. Housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Isolating any resident will be done only as a last resort when less restrictive measures are inadequate to keep the resident or others safe, according to the Policy. The facility does not have an isolation room or a segregated housing area. There have been no residents isolated in the last 12 months because he was at risk of sexual victimization.

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:

There are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation(s) that may have led to abuse. A resident may talk to any staff member; put the information in writing and give it to any staff

member; write the information on a grievance form and place the form in the grievance box; the DJJ and advocacy agency hotline numbers are available and accessible; and third parties may report allegations to the facility or the hotline numbers.

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Standard 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

X☐Standard Not Applicable

Auditor Comments:

According to Policy 6.52 and staff interviews, the facility considers resident grievances regarding sexual abuse to be an allegation of sexual abuse and when such a complaint is received, reporting and investigation policies are initiated.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐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 6.53 provides for the residents having access to outside victim advocacy services. A MOU has been obtained with Lakeview Center, Inc. in Pensacola. The information about the services is explained to the resident during the intake process. Residents will be provided access to a phone for the Center's hotline number as requested.

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 6.54 provides information regarding third-party reporting of sexual abuse. Pamphlets about reporting sexual abuse and sexual harassment are available at the check-in counter in

the administration area, accessible to the public and in visitor areas. Posters containing reporting information are displayed in various areas of the facility. A letter is sent to the parent/guardian that provides information about the facility, including how to report abuse.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.61 and the Florida Administrative Code Rule 63F-11 address this standard. All staff members are required to report any allegation of sexual misconduct or youth-on-youth sexual activity to the Central Communications Center (CCC). The Policy states that staff members are prohibited from revealing any related information to anyone other than is necessary. The Policy requires that staff members are to immediately report: any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment; retaliation against residents or staff who report any incidents; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.62 provides steps to take when staff learns that a resident is subject to substantial risk of imminent sexual abuse. The Policy requires staff to takes immediate action to protect the resident. There have been no incidents in the last 12 months 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 6.63, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Executive Director or his designee will notify the head

of that facility as soon as possible but no later than 72 hours and the appropriate investigative agency. In the past 12 months, there have not been any reports of allegations of sexual abuse occurring to a resident while he was in another facility.

Standard 115.364 Staff First Responder 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 6.64 outlines the first responder duties and responses. There have been no allegations that a resident was sexually abused within the last 12 months. Interviews revealed that staff members are aware of their duties.

Standard 115.365 Coordinated Response

☐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:

The coordinated response is incorporated in the facility's Policy 6.65. Interviews with staff support that an institutional plan has been developed and that staff members are familiar with their roles.

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)

X☐Standard Not Applicable

Auditor Comments:

The facility does not maintain any collective bargaining agreements.

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.67 addresses retaliation monitoring. The Director of Operations has oversight of the monitoring for possible retaliation. Staff members engaging in retaliation will receive disciplinary action including and up to termination. Residents engaging in retaliation will receive a disciplinary work detail and loss of privileges. If retaliation conduct is identified, the monitoring would be conducted for no less than 90 days and longer if 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 Comments:

The facility does not have or utilize segregated housing; however, Policy 6.42 addresses the required rights that residents will be afforded if they are isolated from others for safety reasons, as a last resort, until other arrangements can be made.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.71 and FDJJ 1919 address this standard. Administrative investigations are conducted by the DJJ Office of Inspector General (OIG) and criminal investigations are conducted by local law enforcement. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. Both Policies direct facility staff to cooperate with investigations.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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 6.73 and FDJJ 1919 address this standard. The facility's policy provides for staff to notify the resident following an investigation. The notification will be documented. There has not been an allegation of sexual abuse during this audit period.

Standard 115.376 Disciplinary Sanctions for Staff

☐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 6.76 provides for disciplinary sanctions for staff to be up to and including dismissal for violation of the facility's zero-tolerance against sexual abuse and sexual harassment. In the past 12 months, no staff has been terminated or has resigned for violating the facility PREA policies.

Standard 115.377 Corrective Action for Contractors and Volunteers

☐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 6.77 addresses the corrective actions regarding a contractor or volunteer engaging in sexual abuse of residents. The volunteer or contractor will be reported to law enforcement and to relevant licensing bodies. According to the policy, the contractor or volunteer will be

prohibited from having contact with residents. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative agency for allegations of sexual abuse.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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:

According to Policy 6.78, any resident found in violation of the facility's zero tolerance policy regarding sexual abuse, sexual assault, sexual misconduct or sexual harassment against another resident will receive disciplinary sanctions after a formal disciplinary process. The facility does not use isolation as a disciplinary sanction. The Policy also states that the facility may discipline a resident for sexual contact with staff only upon finding that the staff did not consent to such contact. There has been no incident of resident-on-resident sexual abuse in the past 12 months.

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

☐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 6.81 provides that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse during an intake screening will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed provided awareness of the policy and practice.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐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 6.82 requires that treatment services to every victim be provided at no cost to the victim. It also states that services will be provided regardless of whether or not the victim

cooperates with any investigation due to the incident. Staff interviews confirmed that the nature and scope of the medical and mental health services will be 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)

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 6.83 addresses ongoing medical and mental health care for sexual abuse victims and abusers. It also states that the appropriate tests will be performed. It states that the facility will attempt to obtain a mental health evaluation within 60 days of learning of resident-on-resident abusers and offer treatment deemed appropriate by a mental health practitioner. Interviews confirmed awareness of the Policy and how it would be implemented.

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 6.86 states that the sexual abuse incident review team will include upper-level management and allow for input from line supervisors, investigators, and medical and mental health staff.

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 and interviews with staff confirmed that DJJ collects incident-based, uniform and aggregated data regarding allegations of sexual abuse at facilities under its direct control using a standardized instrument. The Policy requires the collection of accurate, uniform data for every allegation of sexual assault. The facility provides DOJ with data as requested.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

FDJJ 1919 states that the statewide PREA Coordinator will review the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives. The Policy also states that an annual report will be prepared. A review of documentation confirms this practice.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According FDJJ 1919, it is required that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed. A review of documentation confirmed the practice.

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

December 20, 2014

Auditor Signature

Date