Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report September 20, 2018

Auditor Information

Name: Shirley L. Turner	**Email:** shirleyturner3199@comcast.net
Company Name: Correctional Management and Communications Group	
Mailing Address: P. O. Box 370003	**City, State, Zip:** Decatur, GA 30037
Telephone: 678-895-2829	**Date of Facility Visit:** September 5-6, 2018

Agency Information

Name of Agency Sequel Youth and Family Services		**Governing Authority or Parent Agency** *(If Applicable)*	
Physical Address: 1131 Eagletree Lane, SE		**City, State, Zip:** Huntsville, AL 35801	
Mailing Address: Same as Above		**City, State, Zip:**	
Telephone: 256-880-3339		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: **"**To prepare our clients to lead responsible and fulfilling lives by providing mentoring, education, and living support within a safe, structured, dynamic environment--whether on one of our campuses, in the community, or in their own homes."

Agency Website with PREA Information: www.sequelyouthservices.com

Agency Chief Executive Officer

Name: John Stupak	**Title:** Chief Executive Officer
Email: john.stupak@sequelyouthservices.com	**Telephone:** 215-284-5043

Agency-Wide PREA Coordinator

Name: Sonja Schierling	**Title:** Corporate Quality Manager
Email: sonja.schierling@sequelyouthservices.com	**Telephone:** 941-526-8763

PREA Coordinator Reports to: Suzanne Young, Vice President of Administrative Services	Number of Compliance Managers who report to the PREA Coordinator 18

Facility Information

Name of Facility: Pompano Youth Treatment Center				
Physical Address: 3090 North Powerline Road, Pompano Beach, FL 33069				
Mailing Address (if different than above):				
Telephone Number: 954-984-4545				
The Facility Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other
Facility Mission: "To protect the public by preparing trouble youth for the future, to reduce juvenile crime and delinquency in Florida and to prevent the creation of new victims."				
Facility Website with PREA Information: www.sequelyouthservices.com				
Is this facility accredited by any other organization? ☒ Yes ☐ No				

Facility Administrator/Superintendent

Name: Gary Brannen	**Title:** Executive Director
Email: gary.brannen@sequelyouthservices	**Telephone:** 954-984-4545

Facility PREA Compliance Manager

Name: Gary Brannen	**Title:** Executive Director
Email: gary.brannen@sequelyouthservices	**Telephone:** 954-984-4545

Facility Health Service Administrator

Name: Carol Locke	**Title:** Nurse Manager
Email: carol.locke@sequelyouthservices.com	**Telephone:** 954-984-4545

Facility Characteristics

Designated Facility Capacity: 24	**Current Population of Facility:** 22
Number of residents admitted to facility during the past 12 months	37
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	37

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	37
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	13-19 Years
Average length of stay or time under supervision:	6-9 Months
Facility Security Level:	Staff Secure
Resident Custody Levels:	Staff Secure
Number of staff currently employed by the facility who may have contact with residents:	30
Number of staff hired by the facility during the past 12 months who may have contact with residents:	45
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2

Number of Buildings:	1	**Number of Single Cell Housing Units:**	0
Number of Multiple Occupancy Cell Housing Units:	1		
Number of Open Bay/Dorm Housing Units:	0		
Number of Segregation Cells (Administrative and Disciplinary:	0		

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): The camera monitoring system is located in the offices of the Executive Director and the Assistant Program Director. Cameras are located in strategic areas within and outside of the building. The system has the capability to store data for 30 days. No cameras are located in restrooms.

Medical

Type of Medical Facility:	Onsite Medical Clinic
Forensic sexual assault medical exams are conducted at:	Nancy J. Cotterman Center

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	2
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Pompano Youth Treatment Center is located in Pompano Beach, Florida and serves male juvenile offenders. The onsite audit phase of the Prison Rape Elimination Act (PREA) audit was conducted on September 5-6, 2018 by Shirley Turner, certified U. S. Department of Justice PREA Auditor. The facility's initial PREA audit was completed with a written report in 2015. The current audit was attained and assigned to the Auditor by Correctional Management and Communications Group, LLC (CMCG) located in Minneola, Florida.

The facility is operated by Sequel Youth and Family Services through a contract with the Florida Department of Juvenile Justice and is a residential staff secure program. The facility's designed capacity is 24 and there were 22 residents in the facility on the first day of the audit. Residents between the ages of 13-19 years old are served in the facility. There are no known existing conflicts of interest regarding completion of this audit and there were no barriers in completing any phase of the audit.

Audit Methodology

Pre-Onsite Audit Phase

The Florida Department of Juvenile Justice (FDJJ) statewide PREA Coordinator facilitated a conference call between the Auditor and the facility/agency staff members. The call provided for information sharing regarding the PREA site visit, data gathering and submitting documentation. The Auditor discussed access to the facility and staff for formal and informal interviews, site visit itinerary, and goals and expectations prior to the site The PREA Auditor was in communication with the FDJJ PREA Coordinator and the facility's Executive Director.

The PREA Compliance Manager's role is assumed by the Executive Director of the facility. During the conference call, the facility staff was receptive to the audit process and knowledgeable of the role of the Auditor and the expectations during each stage of the PREA audit. The facility staff had previously participated in a PREA audit in 2015 facilitated by the FDJJ PREA Coordinator. The Executive Director and the Assistant Program Director indicated they had experienced previous PREA audits.

The audit notice was posted at least six weeks prior to the onsite audit. The pictures of the posted notices were taken with the locations identified and emailed to the Auditor. The audit notice was posted on brightly colored paper using print that was easy to see and read. They were strategically placed throughout the facility, accessible to residents, staff, visitors,

contractors, and volunteers. The notices were posted at varying eye levels in the lobby, hallways, living units, and common areas. The posted audit notices contained the Auditor's contact information and information regarding confidentiality. No correspondence was received during any phase of the audit. Further verification of the postings was made through observations during the site review. The original notice was provided to the facility by the FDJJ PREA Coordinator which was provided to him by to the Auditor.

The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. This information was received by the Auditor weeks before the site visit. An initial assessment was conducted of the information provided and the Auditor provided an initial review or issue log to the Executive Director/PREA Compliance Manager, requesting additional information. The documentation on the flash drive was organized by each standard, including the identified provisions of each standard. Additional information was received prior to the site visit and provided and/or explained during the site visit.

The Auditor provided the Executive Director with a document by CMCG titled, "Information Requested to Determine Staff and Residents to be Interviewed During the On-Site PREA Audit." The document was completed and returned to the Auditor. The document requested the identification of staff members who served and performed in specific PREA related specialized roles within the facility, including volunteers and contractors who have contact with residents. The document requested a list of direct care staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation.

The Auditor communicated with the Executive Director to confirm schedules and to clarify specialized PREA roles. A current resident roster was also provided to the Auditor. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff and residents, including targeted resident interviews.

The facility provided the PREA lists and information before or during the site visit that assisted with the following determinations and interview selections:

Lists/Information	Comments
Complete Resident Roster	An up-to-date roster was provided prior to the site visit.
Youthful inmates/detainees	Youthful inmates/detainees are not housed in this facility.
Residents with disabilities	None Identified
Residents who are Limited English Proficient	None Identified.
LGBTI Residents	None Identified.
Residents in segregated housing	No segregated housing in the facility.
Residents in Isolation	Isolation is not used.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization	None Identified

during risk screening.	
Staff roster for the time of the site visit.	Roster provided during the pre-onsite phase and onsite.
Specialized Staff	Specialized staff was identified on interview document sent to the facility.
Contractors who have contact with the residents	Contractors were identified.
Volunteer who has contact with the residents	Volunteers identified during the site visit.
All grievances/allegations made in the 12 months preceding the audit	No PREA related grievances were provided.
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	Provided for the 12 months preceding the audit. One administrative investigation was conducted.
Hotline calls made during the 12 months preceding the audit	There is indication no hotline calls made during the 12 months preceding the audit.
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	Provided the documentation of the one allegation of sexual abuse in the 12 months preceding the audit.

The Auditor reviewed the lists/documents provided and conferred with the Executive Director/PREA Compliance Manager for clarity as needed. As a result of the information received, the Auditor developed an interview schedule consisting of specialized and random staff and residents.

General and specific information about the facility and the programs and services provided are detailed on the agency's website. An array of information, pictures of the facility and contact information may be accessed. The agency's and FDJJ's websites contain PREA information. The PREA audit report for the initial audit in 2015 is located on FDJJ's website. Internet research of the facility revealed general information about the facility.

Onsite Audit Phase

Upon arrival to the facility, the Auditor was required to sign in, searched and keys were taken and locked in the key box by the administrative assistant. The Auditor was greeted by the Executive Director/PREA Compliance Manager and an entrance conference was conducted in his office. The Auditor provided a review of the audit process, site visit activities and the itinerary for the two-day audit period.

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted by the Executive Director. The tour included all areas of the facility. Staff members were observed providing direct supervision to the residents during leisure activities inside in the multi-purpose room and outside in the recreation area. Residents were also observed in a group session, facilitated by treatment staff.

The Auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was somewhat familiar with the layout of the facility. The program is housed in one main building which includes one multiple occupancy housing unit, containing 13 rooms. One

to two residents are housed in each room. Located on the outside grounds are four mobile units used for the education program and houses three classrooms and an office. The files of residents were observed to be maintained in a secure manner. The resident population on the first day of the onsite audit was 22.

During the comprehensive site review, the printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, such as living unit, hallways, lobby and common areas for residents, staff and visitors. The notices contained large enough print to make them accessible and easy to see and read. Posted signs regarding PREA material contain contact information for reporting allegations of sexual abuse or sexual harassment. The posted information includes instructions on accessing the 24/7 hotlines for reporting allegations through the abuse hotline and for requesting advocacy services through the Nancy J. Cotterman Center located in Ft. Lauderdale, Florida. Posters about the Nancy J. Cotterman Center are placed in the facility and contain the advocacy services provided by the agency and information about confidentiality, in addition to the hotline number.

The Executive Director provided documentation of correspondence with the Case Manager/Counselor, of the Nancy J. Cotterman Center introducing himself as the new facility administrator and requesting continued accessibility to advocacy services for residents when needed. The written response affirmed that the advocacy agency would continue to be a resource for the facility, providing services as needed. The Executive Director stated during the site visit he will continue with the process of obtaining a Memorandum of Understanding that will outline the specific services to be provided to residents when requested. The Auditor encouraged and recommends that the Executive Director continues his efforts to obtain a Memorandum of Understanding regarding the provision of advocacy services.

Informal interviews were conducted with staff regarding resident activities and staff duties as the site review progressed through the different areas of the facility. The site review included the living unit; education mobile units; lobby; multipurpose room/cafeteria; offices; conference room; patio; and outside grounds. During the comprehensive site review, the intake process was described and the daily scheduled activities and staff supervision were discussed by the Executive Director. There were no new admissions to the facility during the site visit.

The telephone was observed in the hallway near the multi-purpose room where residents have access to call directly and report allegations of abuse or request advocacy services. The telephone was tested and determined to be in working order however there is a lengthy wait time to connect with an operator. Directions for accessing the hotlines for reporting allegations of abuse and for requesting advocacy services are posted at the phone. Posters regarding advocacy services include the limitations of confidentiality.

Outside of the housing unit door is a sign informing female staff to announce their presence upon entering the unit. All residents interviewed stated the female staff follow the directions of the sign and let them know when they are entering the housing unit. The practice was experienced and observed during the comprehensive site review. The facility does not have segregated housing and isolation is not used.

The comprehensive site review allowed for many observations about the daily activities, program services and operations. Visibility is enhanced with the strategic use of cameras and it was recommended to the Executive Director to increase the visibility of offices where there are windows in doors through the removal of objects in/on the window. There are no cameras in bathrooms and reasonable privacy is provided to residents when they use the toilet, change clothes and shower. Medical request and grievance forms and locked boxes are posted in the hallway adjacent to the multipurpose room, accessible to all residents. Access to writing utensils needed for completing the forms is provided to all residents. Recommendations for signage postings were made and received regarding indicating areas of the facility where residents were not allowed or only allowed with staff supervision. The doors to closets and storage rooms are kept locked.

Interviews

Forty-five staff members are currently employed at the facility that may have contact with residents. A total of 22 residents were in the facility on the first day of the site visit. Ten residents were interviewed after randomly selecting the names from the facility population report and previous and site visit inquiries regarding targeted interviews. Residents were randomly selected for interviews from the resident roster, considering the make-up of the population and input by administrative and specialized staff regarding the identified vulnerable categories. There were no targeted interviews conducted as a result of requested information and conferring with management and program staff.

Twelve random staff members were interviewed covering all shifts and 10 individual specialized staff members were interviewed based on their job duties and PREA roles, including three contractors. Two volunteers were in the building on the first day of the audit however they were new to the facility and still in training. The Executive Director was interviewed in the roles of superintendent and PREA Compliance Manager. His interview in the role of PREA Compliance Manager is included in the group of specialized staff. Although eight individuals were identified for specialized interviews, the specialized interviews conducted totaled 13 due to staff members in this category serving in more than one PREA related specialized role.

The volunteers will be providing support services in the mental health section, working under the direction of the Clinical Director. The contractors interviewed provide educational services through the Broward County School District. The interviews with residents, staff, and contractors indicated their receipt of PREA training which was also verified by a review of documentation, including training materials. Staff and resident interviews were conducted in the privacy of the conference room.

The Auditor conducted 10 random resident interviews. There were no targeted interviews conducted due to no residents being identified in such categories. The Auditor conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews
PREA Compliance Manager	1
Medical Staff	1

Mental Health Staff	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
Volunteers who have Contact with Residents	0 (2 in training onsite)
Contractors who have Contact with Residents	3
Investigative Staff	1 (agency - FDJJ)
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Intake Staff	1
Number of Specialized Staff Interviews	13
Number of Random Staff Interviews	12
Total Random and Specialized Interviews	25
Total Interviews plus Executive Director	26

Investigations

The facility reports one allegation of sexual abuse by a staff member during the past 12 months. The allegation was reported by another staff member. Documentation indicates the previous facility administrator reported the allegation as required to the FDJJ Central Communication Center and others, including the guardian.

According to the investigation documents and the Executive Director, the Office of the Inspector General (OIG) conducted an administrative investigation of the allegation. The report indicates that the Broward County Sheriff's Office (BSO) was also contacted and cleared the OIG to proceed with the administrative investigation. As a result of the investigation completed by the BSO, confirmed by their Incident Investigation Report, the case was closed as "pending inactive". The case was closed by the OIG as unfounded regarding sexual abuse as a result of the administrative investigation.

Onsite Documentation Review

The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the Pre-Onsite Audit Phase and the Onsite Audit Phase the Auditor collectively reviewed a sample of personnel files of the staff selected to be interviewed, including documentation of criminal background checks occurring. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed.

The secondary documentation reviewed included but was not limited to various forms; risk screening instrument; PREA education and training acknowledgement forms; training records; training curricula; checklists confirming delivery of services; sexual abuse coordinated response plan; investigation report; annual staffing plan assessment; staff schedules; evidence of unannounced rounds; organization chart; letters confirming services; investigation report; and other documentation.

After the completion of the site visit process, an exit briefing was held in the office of the Executive Director and included the Assistant Director of Programs. The exit briefing served to review the onsite process and review program strengths and additional information needed and the reason for the additional information. A description of the pending information was provided by the Auditor which would indicate refresher training provided to residents regarding the description of advocacy services. The need for the refresher education session for residents was identified as a result of the interview responses by residents regarding advocacy services.

Additionally, during the exit briefing, the Auditor reviewed the recommendation for continuing the process of obtaining a Memorandum of Understanding with the Nancy Cotterman Center. The timelines for the submission of PREA reports were also discussed. The administrators were given the opportunity to ask questions related to the audit process and the corrective action.

Post Onsite Audit Phase

The Auditor interviewed the Crisis Intervention Specialist of the Nancy J. Cotterman Center and the interview confirmed the available services to residents which include but are not limited to hotline services; crisis intervention; accompaniment through the investigative interview; forensic medical examination by a qualified medical practitioner; and community referrals. This information was also encompassed on the posters in the facility. The Crisis Intervention Specialist indicated the services will be provided upon request by the resident, facility staff or law enforcement. The interview also revealed that the provision of services to residents in the facility does not rest on obtaining a written agreement between the two facilities.

The pending documentation requested and required to confirm completion of the refresher training provided to residents regarding advocacy services was provided. The documentation included signed rosters indicating residents' attendance. The final report was concluded on the posted date. The Auditor determined the documentation received regarding the implementation of the corrective action and the results of the site visit confirmed all the standards were met. The report was submitted to the FDJJ PREA Coordinator to be subsequently forwarded to the facility.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Pompano Youth Treatment Center is located in Pompano Beach, Florida and serves male juvenile offenders. The facility is a 24-bed staff secure substance abuse treatment program managed by Sequel Youth and Family Services through a contract with the Florida Department of Youth Services. The program uses evidenced-based curriculum to support the treatment

services provided, including Thinking for a Change, Aggression Replacement Training, Impact of Crime, and Living in Balance.

A behavior management system exists that support holding the residents accountable for their actions and to assist them in maintaining compliance with the program rules and expectations. Residents served in the program are from 13 to 18 years old. Residents are expected to know, live by and exhibit daily the Six Pillars of Conduct which are: Respect; Responsibility; Trustworthiness; Caring; Fairness; and Citizenship. Residents also have the opportunity to engage with the community consistent with Restorative Justice Principles.

The program is housed in one main building, contains 13 rooms on the housing unit with one-two residents assigned to each room. Two of the rooms have been designated as honor rooms and house two residents each. A room, labeled the multi-sensory room, where therapy occurs, is located on the living unit and has been accessorized to convey a serene environment. The room is also used for family sessions and for visits with residents and their younger siblings. Another room on the living unit is used as a game room and for group sessions. A group session was observed occurring during the comprehensive site review.

The entrance lobby contains a reception area and seating for visitors. The building contains offices; medical clinic, conference room; laundry room; kitchen; and a large room where a section of it is used as the dining room and visitation and the other section is used as the dayroom for residents. The bathrooms provide the residents with a reasonable amount of privacy for changing clothes, using the toilet and taking showers. A shower curtain hangs at each shower and doors are connected to each toilet stall. Isolation is not used at this facility. Located in the back of the building on the outside is a large patio, which contains weight equipment, and the grounds provide for basketball and other recreation activities. There are four portable buildings on the outside that are used for education services. The grounds also contain a garden area that is under construction by the residents under staff supervision.

The housing unit contains reporting information and guidelines for residents to follow that will help keep them safe. Additional staff offices are located on the housing unit. Space is identified in the facility for individual, group and family counseling sessions; visitation; education; and other activities. There is no camera access to the restrooms and cameras are strategically placed inside and on the outside of the building. The camera system supplements direct supervision provided by direct care staff members. There have been no updates to the electronic monitoring system during this audit period.

Information regarding reporting sexual abuse and sexual harassment, including third-party reporting is posted in the lobby and throughout the facility. The third-party reporting information is available and accessible to visitors, residents, contractors, and employees. Administrative investigations are conducted by the FDJJ OIG and there is no facility-based investigator in the facility. When it is determined an allegation is of a criminal nature, the case is referred to the Broward County Sheriff's Office. Allegations of sexual abuse are also reported to and may be investigated by the Florida Department of Children and Families.

Mental health services address a variety of issues through individual, group and family counseling. The Clinical Director provides oversight to the mental health and counseling section and additional staff consists of Therapists, Case Managers and a Transition Specialist. A psychiatrist visits the facility weekly. Basic medical services are provided and coordinated by the Nurse Manager with services also provided by the Program Nurse. The medical doctor visits the facility weekly and an optometrist visits every three months. Education services are provided onsite through the Broward County School District and include all course requirements for a standard high school diploma. Residents receive vocational/career training, industry certification, job placement, mentoring, and support services. Industry Certification programs include but are not limited to Microsoft Office Specialist Bundle and Internet Web Professional.

Direct care staff members are responsible for the daily and direct supervision of residents and manage them during their daily activities. Physical education and recreation activities are provided and coordinated by the Recreation Specialist. The staff to resident ratio was observed to be met in all areas of the facility during the comprehensive site review. Management, treatment, and supervisory staff members provide oversite of or participation in processes and activities that contribute to the facility operations.

The resident interviews and documentation confirmed the provision of the programs and services described. The residents indicated during the interviews, they could communicate with their parents/guardians through telephone calls and visits. Observations during the comprehensive site review revealed adequate space for conducting the programs and services described and visitation. Letters are provided to parents/guardians informing them of the general rules of visitation and the days and times of visitation. These letters also encourage parents/guardians to be a part of the treatment team process and to provide input in the resident's treatment plan.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: 0

Number of Standards Met: 41

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

115.333 – Resident Education

The resident interviews revealed they were not fully aware of the victim advocacy services available to them if they were the victim of sexual abuse. A corrective action was implemented by the Executive Director/PREA Compliance Manager. A PREA education refresher was conducted with the residents to address the role of the Nancy J. Cotterman Center and the identification of advocacy services that can be provided. A Sign-In Sheet was completed showing the name/signatures of each resident and the facilitator. The education sessions were completed during the post onsite audit phase. The signed rosters and date were emailed to the Auditor by the Executive Director. The discussion during the exit conference and the document received confirmed the refresher training occurred.

PREVENTION PLANNING

Standard 115.311: Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26, Prison Rape Elimination Act (PREA)
FDJJ Policy 1919, Prison Rape Elimination Act (PREA) Standards Compliance
Organizational Chart
PREA Pre-Audit Questionnaire

Interviewed:
Executive Director/PREA Compliance Manager
Corporate Quality Manager/ Sequel Youth and Family Services PREA Coordinator
Random Staff
Residents

Provision (a):
An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The facility and FDJJ Policies mandate a zero-tolerance policy toward all forms of sexual abuse and sexual harassment. The policies outline the facility's approach to preventing, detecting, and responding to such conduct. The policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment and include sanctions for those found to have participated in prohibited behaviors. Detection of sexual abuse and sexual harassment is addressed through resident education, staff training, and intake screening for risk of sexual victimization and abusiveness. The Policies include but are not limited to responding to sexual abuse and sexual harassment through reporting, investigations, assessments, crisis intervention, and disciplinary sanctions for residents and staff. The facility has additional policies that support the PREA standards, in addition to 1.26.

Provision (b):
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Facility Policy 1.26 indicates an agency PREA Coordinator for Sequel Family and Youth Services and provides for the designation of a PREA Compliance Manager. FDJJ 1919 provides for a statewide PREA Coordinator for the agency. The facility's Executive Director/PREA Compliance Manager reports directly to the Regional Program Director and has access to the Corporate Quality Manager/PREA Coordinator regarding PREA issues. The interview with the Executive Director confirmed knowledge of the PREA standards and the application of such. The Interview with the Corporate Quality Manager/PREA Coordinator confirmed the roles of the PREA Compliance Manager and the PREA Coordinator. Additionally, the FDJJ PREA Coordinator provides support services to the facility.

Provision (c):
Where an agency operates more than one facility, each facility shall designate a PREA Compliance Manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

The Sequel Family and Youth Services Policy provides for the designation of a PREA Compliance Manager at each facility. The PREA Compliance Manager reports to the Regional Program Director and has access to the agency's PREA Coordinator as indicated by the organization Chart and the facility Policy. The interview with the Executive Director and observations revealed he has the time and authority to perform PREA duties. The interview with the Quality Manager/PREA Coordinator also revealed she has time and the authority to perform the PREA duties.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment, designation of PREA Coordinator for the agency and a PREA Compliance Manager for the facility.

Standard 115.312: Contracting With Other Entities for the Confinement of Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards?

(N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not contract with other entities to house its residents as confirmed by the interview with the Executive Director.

Standard 115.313: Supervision and Monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring:

Generally accepted juvenile detention and correctional/secure residential practices?
☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)
  ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26, PREA
Staffing Plan
Staffing Plan Assessment
Work Schedules
Logbook
PREA Pre-Audit Questionnaire

Interviews:
Assistant Program Director/Intermediate or Higher-l Level Staff
Executive Director/PREA Compliance Manager
Corporate Quality Manager/PREA Coordinator
Random Staff

Provision (a):
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

Facility Policy 1.26 provides details for maintaining the contract staffing ratios of 1:8 during the waking hours and 1:10 during the sleeping hours. The camera system is monitored regularly and the provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interview with the Executive Director and Assistant Program Director, review of staffing plan, work schedules and observations. The work schedules are based on the staffing plan and facility Policy. The Corporate Quality Manager/PREA Coordinator provides an additional review of the staffing plan intermittently and upon request.

Provision (b):
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

Policy provides that in the event that the staffing ratio is unable to be maintained during exigent circumstances, the deviation must be documented. The facility documents there have been no deviations to the staffing plan in the past 12 months. The facility is prepared to document any deviations from the staffing plan. Interviews and observations revealed that the hold-over system is used when shortages occur and staff from other Sequel Youth and Family Services' facilities may be utilized.

Provision (c):
Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

Facility Policy 1.26 provides for a staff to resident ratio of 1:8 during the waking hours and 1:10 during the sleeping hours which is in accordance with the contract. The ratios are maintained by staff providing direct care to residents. The staff to resident ratio was in compliance during the site visit as observed during the comprehensive site review. Since the last PREA audit in 2015 the average daily number of residents has been 23. Since the last PREA audit, the average daily number of residents on which the average daily number of residents on which the staffing plan was predicated is 24.

Provision (d):
Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA Compliance Manager required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

The Policy provides that an annual assessment of the staffing plan is conducted. The Staffing Plan Assessment is conducted annually with the latest being signed on May 22, 2018 by the PREA Compliance Manager and the FDJJ statewide PREA Coordinator. The document reviews but is not limited to the following areas, prevailing staffing patterns; deployment of video monitoring system; and occurrence of unannounced rounds, aligned with this provision of the standard. No corrective actions were identified in the Staffing Plan Assessment.

Provision (e):
Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

Facility Policy provides for the occurrence of unannounced rounds conducted by management staff and for the rounds to be documented. A review of a sample of documented unannounced rounds, support unannounced rounds are conducted by intermediate level and higher level staff for each shift at various times. The areas assessed during the unannounced rounds by the management staff at various times include but are not limited to housing unit and common areas.

The interview with the Assistant Program Director indicated how he ensures that staff does not alert other staff when he is conducting unannounced rounds, including making his rounds at different times. The Policy indicates staff will not alert other staff regarding the occurrence of unannounced rounds. Staff members are not informed of the unannounced rounds and staff members are encouraged not to alert other staff members regarding the unannounced visits.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding supervision and monitoring.

Standard 115.315: Limits to Cross-Gender Viewing and Searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Training Curriculum
Training Sign-in Sheets
Posted Shower Protocols

Interviews:
Executive Director
Random Staff
Residents

Provision (a):
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

The Policy prohibits cross-gender searches of any type except in exigent circumstances or by a medical practitioner and the exigent circumstances must be documented in the logbook. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the interviews, no such searches have been conducted.

Provision (b):
The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

The Policy prohibits cross-gender searches of any type except in exigent circumstances or by a medical practitioner and the exigent circumstances must be documented in the logbook. The facility provides training on how to conduct these searches in exigent circumstances using training curricula, including PowerPoint training presentations. Staff participation in the training is recorded with training sign-in sheets.

Staff interviews confirmed they are aware of the restriction of conducting cross-gender pat-down searches except in exigent circumstances. No residents interviewed reported a female staff member conducted a pat-down search of their body. The evidence shows cross-gender pat-down searches have not occurred at the facility, but the facility is prepared for them to be conducted in exigent circumstances. Staff interviews confirmed cross-gender searches would only be conducted due to exigent circumstances.

Provision (c):
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches may be conducted only in exigent circumstances which random staff interviews summarized as an emergency and no available male staff. The Policy indicates that in the event a cross-gender search is warranted pursuant to an emergency circumstance, it must be approved and the justification for the search documented in the logbook. The evidence shows the facility is prepared to document and justify all cross-gender pat-down searches however the practice is that females do not perform searches.

Provision (d):
The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

The Policy supports that the facility will enable residents to shower, perform bodily functions, and change clothes without non-medical staff of the opposite gender viewing them except in exigent circumstances or during routine room checks. Shower protocols are posted which support the practice. Staff members of the opposite gender are required to announce their presence upon the housing unit. This practice was confirmed through observation of signage indicating such, observations of the practice, and interviews with residents and staff. No residents interviewed reported ever having been naked in full view of female staff while showering, changing clothing, and performing bodily functions.

The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia. Based on the review of the documentation, staff and resident interviews, and observations, the facility follows this provision of the standard. Viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes.

Provision (e):
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

The Policy prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. The practice would be that if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. One hundred percent of direct care staff received the training on conducting cross-gender pat-down searches and searches of transgender and intersex residents. Staff interviews confirmed they are aware of Policy prohibiting them from conducting a physical examination of transgender or intersex resident solely for the purpose of determining the resident's genital status.

Provision (f):
The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

The Policy supports that staff will be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews support the training is conducted. Training participation is documented with sign-in sheets. The evidence shows staff members are trained in how to conduct cross-gender pat-down searches, and

searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:
Based on the reviewed documentation and interviews, the facility follows this provision of the standard.

Standard 115.316: Residents with Disabilities and Residents who are Limited English Proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility 1.26

Letters, Broward County School District Personnel
Posted PREA Information

Interviews:
Executive Director/PREA Compliance Manager
Random Staff

Provision (a):
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

The facility Policy and a letters from the Americans with Disabilities Act (ADA) Coordinator and Intern Principal with the Broward County Public Schools address this standard. The Policy and the letters address the provision of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, performance of first responder duties, or the investigation of the allegations. Random staff interviews and an interview with the Executive Director confirmed this information. Qualified facility staff and contractors also provide identified support services to residents.

Provision (b):
The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

A Letter from the Intern Principal with Broward County Public Schools indicates assistance with residents who are limited English proficient. Language services are provided through a contract with the agency and Language Line Solutions. The evidence shows that each resident has an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment.

Provision (c):
The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could

compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

Policy prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents are not and have not been used to relate PREA information to or from other residents. There were no identified residents in need of interpreter or translation services during the site visit.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited English proficient. Residents with disabilities and who are limited English proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26
FDJJ Policy, 1800, Background Screening
Personnel Files

Interview:
Human Resources/Business Manager

Provision (a) & (f):
(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(f) The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Facility and agency Policies address hiring and promotion processes and decisions and background checks. The background checks occur prior to employment and at least every five years thereafter, in accordance with the standard. Ten complete personnel files were reviewed onsite and documents and processes were discussed with the Human Resources/Business Manager. Initial background checks are conducted prior to employment and subsequent background checks are conducted every five years. This information was confirmed through a review of the personnel files and interview with Human Resources/Business Manager.

The interview and review of Policies provided details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. The forms completed and included in the personnel files are responsive to the above provisions of this standard. All applicants are asked about any prior misconduct involving any sexual activity and the document must be completed prior to a background check being conducted. The documentation, interview and Policies support the facility does not hire anyone who has engaged in sexual abuse in a prison, jail, community confinement facility, or anyone, who has used or attempted to use force in the community to engage in sexual abuse.

Provision (b):
The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The Policies support that the facility does not hire or promote anyone who has been civilly or administratively adjudicated to have been convicted of engaging in or attempted to engage in sexual activity by any means. The interview was aligned with the standard and the personnel documents show the inquiries made during the application process regarding previous misconduct. The evidence shows the facility considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview, the facility follows this provision of the standard.

Provisions (c) & (d):
(c) Before hiring new employees or **(d)** contractors who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the interview. Best efforts are made to obtain information on prior substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Based on the review of documentation and interview, the facility follows this provision of the standard.

Provision (e):
The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

Initial background checks are conducted and in cooperation with the FDJJ Background Screening Unit and state and local authorities, a background check is conducted every five years. The interview with the Human Resources/Business Manager and a review of Policies provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard.

Provision (g):
Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

According to the interview, staff has a continuing duty to report related misconduct. This information is provided to all new employees during orientation training conducted by the Human Resources/Business Manager. Policy supports that omission of sexual misconduct or providing false information will be grounds for termination. The interview also revealed that an electronic alert from the FDJJ Background Screening Unit is provided to the Human Resources/Business Manager regarding the arrest of a staff member

Provision (h):
Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The interview with the Human Resources/Business Manager revealed the facility would not provide this information; a referral would be made to the corporate office.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility meets the provisions of the standard regarding hiring and promotion decisions.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The monitoring system supplements direct supervision provided by staff members. The interview with the Executive Director, review of PREA Pre-Audit Questionnaire, and observations revealed no update to the video monitoring system since the last PREA audit conducted in 2015. No substantial modification to the facility has occurred since the last PREA audit, as reported and observed.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
  ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy 1.26
Correspondence with Nancy J. Cotterman Center Staff
Posters and Brochure
PREA Compliance Information Sheet

Interviews:
Random Staff
Executive Director
Clinical Director

Provisions (a) & (b):
(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

The Policy indicates a uniform evidence protocol will be followed regarding investigations of sexual abuse in accordance with the standard. The facility has a PREA Compliance information sheet which is provided to law enforcement agencies prior to conducting an investigation regarding the PREA requirements. The facility has no investigators. Administrative investigations are conducted by the FDJJ Office of Inspector General. Referrals for investigations are made to the Broward County Sheriff's Office when they are criminal in nature. The random staff members' interviews confirmed awareness of protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

Provision (c):
The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The facility Policy states forensic medical examinations will be conducted at the Nancy J. Cotterman Center conducted by Sexual Assault Forensic Examiners (SAFE) or Sexual Assault Nurse Examiners (SANE). When a SAFE or SANE is not available, a qualified medical practitioner will conduct the examination. The communication between the Executive Director and a representative from the advocacy agency and those interviews indicate services will be provided to the facility upon request by facility staff, resident or law enforcement. The literature about the advocacy agency supports forensic examinations will be provided at no cost to the victim. No forensic exams have been conducted during this audit period. The Executive Director states he continues to work on a formal written agreement for services as indicated through the interview.

Provisions (d) & (e):
(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. **Provision (e)** As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

Victim advocacy services have been confirmed to be provided when requested. The services that will be provided to residents, as verified, include but are not limited to 24-hour hotline access; crisis intervention services; victim/survivor follow-up; and forensic medical examinations. General information regarding

advocacy services is provided to the residents during the intake process and is posted in various areas of the facility. A refresher session was recently conducted with the residents to ensure their knowledge of the services that will be provided by the advocacy agency, if they are needed.

Provisions (f) & (g):
(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section. **Provision (g)** The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

Investigations of allegations of sexual abuse that are criminal in nature are conducted by the Broward County Sheriff's Office in accordance with the agency's policy and the provisions of the standards. The Florida Department of Children and Families are also contacted regarding allegations of sexual abuse.

Provision (h):
For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The Clinical Director is a qualified facility staff member who may serve as an advocate for a resident when a community-based organization is unavailable.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

Standard 115.322: Policies to Ensure Referrals of Allegations for Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Investigation File
PREA Audit Pre-Audit Questionnaire

Interviews:
Random Staff
Executive Director

Provision (a):
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs 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 facility reports one allegation of sexual abuse by staff. The Policy and interviews support the cooperation between the facility staff and an investigator.

Provision (b) and (c):
The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. **Provision (c):** If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

PREA reporting information and policy are located on the both agency's websites and within the facility, accessible to the public. Reporting information is also posted in various areas of the facility including but not limited to the living unit and common areas. The posted information is accessible to residents, staff, contractors and visitors. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the trained agency investigators of the FDJJ Office of Inspector General. Allegations that are criminal in nature are investigated by the Broward County Sheriff's Office. The Florida Department of Families and Children are also notified regarding allegations of sexual abuse.

During the past 12 months there was one allegation of sexual abuse which was staff-on-resident. The case was investigated by the Sheriff's Office and the Office of the Inspector General. The criminal investigation was closed with not charges filed and the administrative investigation was determined as unfounded.

Provision (d):
Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The facility includes in its PREA Policy information regarding investigations and the Office of Inspector General has Policy in place regarding conducting investigations in confinement settings.

Provision (e):
Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Department of Justice is not responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment at the facility.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Training Curricula
Training Sign-In Sheets
Electronic Training Records
Training Acknowledgement Statements

Interviews:
Random Staff
Executive Director

Provisions (a) and (c):
The agency shall train all employees who may have contact with residents on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
(11) Relevant laws regarding the applicable age of consent.
(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The facility Policy addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented. All random staff interviewed and the Executive Director reported the training is provided as required. All direct care staff members interviewed and document review verified the general topics in this standard provision were included in the training. The training records and interviews confirm the training occurs.

Provision (b):
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses males and the training considers the needs of the population as determined by a review of training curricula and interviews with random staff.

Provision (d):
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy provides all training be documented. Training is documented in different ways, sign-in sheets, acknowledgement statements, certificates, and electronic records. The Auditor reviewed several examples for verification of the training occurring and the training was verified through staff interviews. The facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Training Acknowledgement Statements
Training Curriculum

Interviews:
Contractors
Clinical Director

Provision (a):
The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The Policy requires volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. Interviews with contractors verified the training occurs and that is based on their job responsibilities. A review of training records and interviews document the training occurs. The Clinical Director and a review of the curriculum verified the training occurs for the volunteers which were in the training phase during the site visit.

Provision (b):
The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

A review of the training curriculum for volunteers and interview with the Clinical Director and contractors revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The contractors and volunteers 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 contractors and volunteers. The contractors revealed their awareness of the facility's zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Provision (c):
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

Sign-in sheets, acknowledgement statements, curriculum, and/or interviews document the training occurs for contractors and volunteers.

Conclusion:
The Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Youth Handbook
PREA Education Acknowledgement Statements
Refresher Training Sign-In Sheets

Interviews:
Residents
Case Manager/Intake Staff
Executive Director

Provisions (a) and (b):
During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. **Provision (b):** Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Facility Policy provides that all residents admitted to the facility receive PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. The Case Manager who provides PREA education to residents

and the residents interviewed confirmed that PREA education sessions occur. Orientation is provided to residents during the intake process and is age-appropriate, based on staff and resident interviews.

The intake staff's interview revealed she ensures residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. The PREA education sessions include a review of the PREA brochure and general information. The residents sign acknowledgement statements confirming their receipt of the PREA education. A review of documentation showing dates and indicating residents' participation in PREA education sessions and interview with the Case Manager confirmed the PREA education sessions occur. The PREA related information is provided to staff in policies and procedures, training and staff meetings.

The resident interviews revealed they were not fully aware of the victim advocacy services available to them if they were the victim of sexual abuse. A corrective action was implemented by the Executive Director/PREA Compliance Manager. A PREA education refresher was conducted with all residents to address the role of the Nancy J. Cotterman Center and the identification of advocacy services that can be provided. Sign-In Sheets were completed showing the signed name of each resident. The education sessions were completed during the post onsite audit phase. The training agenda and the signed rosters/date were emailed to the Auditor. The documents received and the conversation with the Executive Director during the exit conference confirmed the refresher training.

Provision (c):
Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Based on the evidence shown in provisions (a) and (b), all residents received PREA education.

Provision (d):
The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Resource documentation was reviewed of for the provision of accommodations and supportive services for residents in the aforementioned areas. PREA information is available in English, Spanish and other prominent languages of the facility population. The agency has arrangements for the use of Language Line Solutions for interpreting and translation services. Staff interviews confirmed residents are not used as translators or readers for other residents. During the resident interviews, general information about PREA was provided.

Provision (e):
The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents were aware of general PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for

reporting allegations of sexual abuse or sexual harassment. The Case Manager was interviewed regarding PREA education for residents. She ensures residents' receipt of the information.

Provision (f):
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to assist in eliminating incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment in different was such as telling a staff member; telling a family member who may report the allegation for them; access to the hotlines to report allegations of sexual abuse or sexual harassment; and may complete a grievance form or medical request form. Each resident is provided a Youth Handbook which contains information regarding reporting allegations of sexual abuse and sexual harassment. Posters were observed placed throughout the facility and were easy to see and read.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26
The facility does not have facility-based investigators and there are no investigators within Sequel Youth and Family Services to conduct investigations of allegations of sexual abuse and sexual harassment. Policy 1.26 and the interviews confirm this information.

Interviews:
Executive Director
Corporate Quality Manager/PREA Coordinator

Provision (a) & (b):
In addition to the general training provided to all employees pursuant to §115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. **Provision (b):** Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The facility nor its parent agency has investigators. Administrative investigations are conducted by the FDJJ Office of the Inspector General. The Florida Department of Children and Families are also notified of allegations of sexual abuse. Allegations that are criminal in nature are investigated by the Broward County Sheriff's Office.

Provision (c):
The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

The facility nor its parent agency has investigators. Administrative investigations are conducted by the FDJJ Office of the Inspector General. The Florida Department of Children and Families are also notified of allegations of sexual abuse. Allegations that are criminal in nature are investigated by the Broward County Sheriff's Office.

Provision (d):
Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

The facility nor its parent agency has investigators. Administrative investigations are conducted by the FDJJ Office of the Inspector General. The Florida Department of Children and Families are also notified of allegations of sexual abuse. Allegations that are criminal in nature are investigated by the Broward County Sheriff's Office.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding specialized training for investigations.

Standard 115.335: Specialized Training: Medical and Mental Health Care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26
Electronic Training Records

Interviews:
Program Nurse
Clinical Director

Provision (a):
The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

The Policy and facility practice provide medical and mental health staff members receive the regular PREA training as well as the specialized training provided through FDJJ SkillPro electronic training system. Training records document specialized training for medical and mental health staff members. The interviews with the Program Nurse and Clinical Director and a review of training records confirmed completion of training which includes the above provisions.

Provision (b):
If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

Forensic examinations are not conducted in this facility.

Provision (c):
The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

The electronic training records and the interviews with medical and mental health staff confirmed receipt of the required training.

Provision (d):
Medical and mental health care practitioners shall also receive the training mandated for employees under Standard 115.331 or for contractors and volunteers under Standard 115.332, depending upon the practitioner's status at the agency.

Medical and mental health staff completed the general training that is provided for all staff members as documented by training documentation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding specialized training for medical and mental health care.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Vulnerability to Victimization and Sexually Aggressive Behavior (risk screening instrument)

Interviews:
Executive Director
Clinical Director/Staff That Perform Screening for Risk
Residents

Provision (a):
Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

The Policy provides a risk screening occurs within 24 hours upon arrival to the facility. The Clinical Director interviews the resident during the intake process to obtain information about the resident's personal history and behavior in order to reduce the risk of sexual abuse by or upon a resident. The Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) is used as the risk screening instrument. The resident's risk level is reassessed based on the initial screening or when new information is received. Samples of the screening instrument were reviewed by the Auditor. Interviews with residents confirmed they were asked questions like the following examples at intake:
(1) Have you have ever been sexually abused?
(2) Do you identify with being gay, bisexual or transgender?
(3) Do you have any disabilities?
(4) Do you think you might be in danger of sexual abuse at the facility?

Provision (b):
Such assessments shall be conducted using an objective screening instrument.

The objective screening instrument, VSAB, is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of VSABs revealed the initial use of the instrument is conducted upon admission to this facility's and again when deemed necessary.

Provision (c):
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the screening instrument and determined all factors required by this provision of the standard are included. The interview with the Clinical Director confirmed he is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument.

Provision (d):
This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court

records, case files, facility behavioral records, and other relevant documentation from the resident's files.

According to the Clinical Director, the information is ascertained through an interview, probing where indicated. The staff and resident interviews are aligned with the Policy and this provision of the standard. The review of the instrument and interview confirmed the information is ascertained through the resident interview and court packets. Resident interviews revealed the instrument is used during the interview process.

Provision (e):
The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

The Policy provides for appropriate controls be taken to ensure that sensitive information is protected and not exploited. The interview revealed the information is only available to treatment staff, Assistant Program Manager and Executive Director. The Auditor observed the files to be maintained in a secure manner and the online documents are protected. The evidence shows the facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding screening for risk of victimization and abusiveness.

Standard 115.342: Use of Screening Information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
VSAB screening instrument
PREA Pre-Audit Questionnaire

Interviews:
Residents
Executive Director
Clinical Director
Random Staff

Provision (a):
The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

Facility Policy provides guidance to staff regarding the use of the information obtained from the VSAB risk screening instrument. The staff interviews and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified through a review of samples of the completed screening instrument.

Provision (b):
Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Policy supports that any use of isolation of a resident to protect a resident who is alleged to have suffered sexual abuse comply with § 115.342 and provision (a). There is no segregated housing in the facility. A resident will be assigned one-on-one supervision by a staff member if the resident is restricted from the general population. At no time will any resident be denied any legally required educational programs, special education services, daily large-muscle exercise, or medical/mental health care.

No residents were determined at risk of sexual victimization and placed on one-on-one supervision with staff in the 12 months preceding the audit. The interview with the Executive Director and observations confirmed the facility does not use isolation. The residents' rights to daily large-muscle exercise and any legally required educational programming or special education services would be provided, per Policy.

Provision (c):
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The Policy prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy

prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. Housing assignments will be made on a case-by-case basis.

Provision (d):
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The Policy supports housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were no transgender or intersex residents in the facility during the site visit and this audit period. The staff interview confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Based on the review of the Pre-Audit Questionnaire and the interview, the evidence shows the facility follows this provision of the standard.

Provision (e):
Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The Policy states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. This function would be done to review any threats to safety experienced by the resident and the staff is aware of the requirement.

Provision (f):
A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

The resident's concern for his own safety is taken into account through the administration of the screening instrument and this applies to every resident. The residents confirmed in the interviews, they are asked about their safety concerns. The staff interviews revealed staff members are aware of the Policy which requires the provision of the standard.

Provision (g):
Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Facility Policy supports transgender or intersex residents be given the opportunity to shower separately from other residents which is also supported by staff interviews.

Provision (h):
If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.
The Policy states if a resident is isolated pursuant to part (B.2.) of this section, the facility shall document:
a. The basis for the facility's concern for the resident's safety; and
b. The reason why no alternative means of separation can be arranged.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Executive Director/Compliance Manager confirmed the facility does not use isolation. The separation of a resident from the regular population would be documented according to the provisions of the standard.

Provision (i):
Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

The Policy states every 30 days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. Interviews with staff confirmed the facility does not used isolation. Separation is defined by the Policy as a resident being assigned one-on-one supervision with an identified staff member. No residents at risk of sexual victimization were separated from the general population in the 12 months preceding the audit.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding use of screening information. The facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. No residents who identified as transgender or intersex were present during the audit or in the 12 months preceding the audit. The facility is prepared to provide a safe and secure environment and follow all provisions of standard regarding transgender and intersex residents.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Youth Handbook
Grievance Form

Sick Call Request Form

Interviews:
Random Staff
Residents
Executive Director

Provision (a):
The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The Policy addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, 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 such. Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour reporting hotline, as confirmed by resident and staff interviews and observations; tell staff; complete a grievance; or complete a Sick Call Request.

Random staff interviews revealed residents may use the telephone, located near the dayroom or the phone in the Case Manager/Therapist office, to report sexual abuse and sexual harassment. There is a designated locked box and forms in the dayroom for depositing the written forms and residents have access to writing materials as observed and stated by staff. The reporting information was supported by the resident interviews. The telephone was tested during the comprehensive site review and the Auditor was unable to reach an operator due to a lengthy wait period however the phone was determined to be in working order.

The resident receives a Youth Handbook which provides PREA related information, including how to report allegations of sexual abuse. Posters are located on the living unit and other areas visible to residents, staff, contractors, volunteers, and visitors. Residents revealed they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

Provision (b):
The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

Residents may use of the emergency telephone located near the dayroom to report an allegation of sexual abuse or sexual harassment. Signs are posted explaining how to access agencies. Random staff revealed staff could use the emergency phone to report allegations of abuse. Allegations of sexual abuse have not been substantiated during this audit period and the one reported was deemed to not be of a criminal nature. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security, according to facility Policy 1.26, Section E.

Provision (c):
Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to immediately document verbal reports. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a grievance or Sick Call form, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Interviewed staff members were aware of their duty to receive and document third-party reports.

Provision (d):
The facility shall provide residents with access to tools necessary to make a written report.

Writing materials are readily available for residents to complete the accessible forms as observed and indicated by the Executive Director. During the site visit, the Auditor observed the accessibility of forms and writing utensils to the residents.

Provision (e):
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of the telephone hotline; or write a note of grievance.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting. The residents have multiple internal ways to privately report. Reports can be made verbally, in writing, anonymously, and from third parties.

Standard 115.352: Exhaustion of Administrative Remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☐ No ☒ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Youth Handbook

Interviews:
Random Staff
Executive Director
Residents

Provision (a):
An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature. The purpose of the submission of an allegation of sexual abuse through the grievance system provides residents and staff another avenue for ensuring the reporting of allegations and provides staff with the opportunity to protect the resident. During this audit period, there has not been a grievance submitted alleging sexual abuse.

Provision (b):
(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature. The purpose of the submission of an allegation of sexual abuse through the grievance system provides residents and staff another avenue for ensuring the reporting of allegations and provides staff with the opportunity to protect the resident. During this audit period, there has not been a grievance submitted alleging sexual abuse.

Provision (c):
The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. However, according to the Youth Handbook, formal and informal staff interviews, and observations, residents are not required to give a grievance to a staff member and staff members are not permitted to place a grievance in the box for the resident. A locked grievance box is located near the common area for the secure deposit of a resident's grievance.

Provision (d):
(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature.

Provision (e):
(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature.

Provision (f):
(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature.

Provision (g):
The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

The facility is exempt from this standard. The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse. Once the grievance is received, it is reported to the appropriate investigative entities and an investigation may be conducted by the Florida Department of Juvenile Justice, Office of Inspector General; Florida Department of Children and Families; or the Broward County Sheriff's Office when the allegation is criminal in nature.

Standard 115.353: Resident Access to Outside Confidential Support Services and Legal Representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Correspondence Memos
Posted Information

Interviews:
Residents
Executive Director

Provision (a):
The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

General information for advocacy services is a part of the PREA education sessions. Information is also provided through signs and posters in various parts of the facility. The resident interviews did not reveal consistency regarding the services that can be provided by the advocacy agency. However a corrective action plan was implemented and a refresher session was conducted focusing on the advocacy services. The hotline telephone was observed and the contact information for services from the agencies was posted. The telephone was tested and determined to be in working order; there was just a long wait period to communicate with an operator.

Provision (b):
The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

There are posters on the wall about the advocacy agency which contain information regarding limitations of confidentiality.

Provision (c):
The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The facility has correspondence with the Nancy J. Cotterman Center regarding the advocacy services that are available and will be provided upon request whether or not there is a written agreement. However, the Executive Director stated he is following-up regarding the channels to get a Memorandum of Understanding completed with the advocacy agency.

Provision (d):
The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The interviews confirmed residents have access to attorneys and court workers and reasonable access to their parents/legal guardians. The site review revealed areas where residents could meet privately

with a legal representative and the visitation area for visits with family members. All residents interviewed stated family could visit and they provided the days and times of visitation and for phone calls. A review of documentation revealed parents/guardians are sent a letter informing them of the details of visitation and it contains the contact information of the facility.

Residents interviewed confirmed the facility would allow them to see or talk with their lawyer, another lawyer or a court representative privately. The Executive Director confirmed the facility provides residents with reasonable and confidential access to their attorneys or court representatives and reasonable access to parents or legal guardians.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident access to outside confidential support services and legal representation. Residents confirmed they had someone on the outside to report allegations of sexual abuse and sexual harassment if they needed to and these persons could make reports for them and without giving the resident's name.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26

Third Party Reporting form

Interviews:
Random Staff
Residents

§115.354 The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

The Policy addresses third-party reporting and interviews revealed random staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to immediately document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline or a third party reporting form. Third-party reporting information is accessible online.

All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third-party reports such as file a grievance, report to staff or a family member, or utilize the abuse reporting hotline telephone. Information regarding reporting is provided through observed postings located in various areas of the facility accessible to visitors, residents, staff, contractors and volunteers and on the websites. There was one third- party report received during this audit period. The allegation was reported by a staff member. The case was closed by the Broward County Sheriff's Office with no charges occurring and closed by the OIG as unfounded.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance regarding third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Incident Report
Investigation File

Interviews:
Random Staff
Program Nurse
Clinical Director
Executive Director

Provision (a) and (b):
The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. **Provision (b):** The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

The Policy addresses provisions of the standard including providing all staff immediately report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws of the State of Florida. The FDJJ trained investigators conduct administrative investigations and allegations that are criminal in nature are referred to the Broward County Sheriff's Office. Allegations of sexual abuse are also reported to the child welfare agency.

Reporting according to the State's mandatory reporting laws and the agency Policies was evident through document review regarding an allegation of sexual abuse made by a staff member regarding another staff member and a resident. The documents show the reporting by staff in accordance with facility Policies and the requirements of the standard. The staff interviews were aligned with the requirements of the Policies and standard. The review of documentation demonstrates information reported to staff is reported to the appropriate authorities. Staff members are also instructed to

immediately report all allegations of sexual abuse or sexual harassment to the Executive Director or designee.

Provision (c):
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Agency Policy supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Provision (d):
(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.
(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The medical and mental health staff interviewed stated residents are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. The clinical staff interviewed revealed they are mandated reporters. They also indicated informed consent would be documented for a resident 18 years old and over regarding reporting allegations of sexual abuse that did not occur in an institutional setting.

Provision (e):
(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.
(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.
(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Agency Policy provides that reports of allegations of sexual abuse will be promptly made by the Executive Director/designee. Where there is documentation saying the parents/guardians should not be notified, the case worker at the appropriate child welfare agency will be notified. The interview with the Executive Director confirmed if the resident is under the custody of a child welfare agency, the Case Worker will be notified. This information was also verified through Policy review.

Provision (f):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

The Policy provides for all allegations to be reported to the Executive Director/designee and called in to the investigative entities. Third-party and anonymous reports received must also be reported and documented immediately by staff, confirmed by Policy and staff interviews.

Conclusion:
The interviews revealed staff awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations or incidents. The random staff interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately.

Standard 115.362: Agency Protection Duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Grievance Form
Youth Handbook

Interviews:
Executive Director
Random Staff

§115.362
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Agency Policy requires staff to protect the residents through implementing protective measures. Administration of the vulnerability screening instrument provides information that assists and guide staff in keeping residents safe through housing and program assignments. The Youth Handbook provides information to residents regarding how to report allegations and contact information for agencies that may provide additional assistance. The interviews of the random staff and the Executive Director revealed protective measures include but are not limited to alerting the supervisor and other staff and separating the residents including moving to a different room. The Executive Director and the random staff indicated the expectation is that any action to protect a resident would be taken immediately.

The interviews also revealed there were no residents identified to be at substantial risk of imminent sexual abuse in the past 12 months. The interviews with the residents revealed that during the intake process they are asked about how they feel about their safety as part of the inquiries by staff completing paperwork. A review of a sample of screening instruments supports the information provided by residents. The Executive Director reports during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection duties.

Standard 115.363: Reporting to Other Confinement Facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Investigation File

Interviews:
Executive Director
Provisions (a), (b), (c), and (d):
Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. **(b)** Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. **(c)**The agency shall document that it has provided such notification. **(d)** The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

The Policy, procedures and practice provides that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Executive Director/designee notifies the head of the facility or appropriate office of the agency where the alleged abuse occurred and the appropriate investigative agency. Notification should be made as soon as possible but no longer than 72 hours after receiving the information. It must be documented the notification was made, as required by Policy. It is the responsibility of the receiving agency to ensure an investigation is completed. The Executive Director is familiar with the Policy and his responsibilities regarding such situation.

Conclusion:
Based upon the information received and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to other confinement facilities.

Standard 115.364: Staff First Responder Duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Training Curricula

Interviews:
Random Staff

Provision (a):
Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

The Policy and training provide that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to:
a. Separate the alleged victim and abuser;
b. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
c. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence,
The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There were no allegations or incident where staff had to act as a first responder in the last 12 months.

Provision (b):
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

According to the Policy, non-security staff who may act as a first responder must be familiar with their role and how to respond in that role. The duties would include alerting security or other staff and requesting the resident not take any actions that could destroy physical evidence.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding staff first responder duties.

Standard 115.365: Coordinated Response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Coordinated Response Plan

Interviews:
Random Staff
Executive Director

§115.365
The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

There is a written Facility Coordinated Response Plan for Reports of Sexual Abuse. A review of training records and interviews with staff confirmed staff members' knowledge of their responsibilities. The Plan coordinates the actions to be taken among staff including first responders, leadership, medical and mental health in response to an incident of sexual abuse.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual

abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility is not responsible for any collective bargaining.

Standard 115.367: Agency Protection Against Retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fears retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Retaliation Monitoring form

Interviews:
Executive Director
Assistant Program Director/Designated Staff Member Charged with Monitoring Retaliation

Provision (a):
The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

The Policy provides for the facility to protect all residents and staff who report sexual abuse or sexual harassment, or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents, or staff. The Assistant Program Director is responsible for retaliation monitoring. The interview with him confirmed he is charged with monitoring for retaliation and how it is conducted.

Provision (b):
The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

The Policy and documentation demonstrate measures to protect staff and residents which are aligned with the measures in this provision such as:

a. Initiating housing changes or transfers for resident victims or abusers;
b. Removing alleged staff or resident abusers from contact with victims; and
c. Emotional support services.

The Assistant Program Director's response is aligned with Policy and he confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, shift changes removing alleged abusers, and emotional support services.

Provision (c):
For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need, according to the Assistant Program Director.

The Policy supports that the monitoring will be conduct and treatment of residents or staff who reported the sexual abuse, and of residents, who were reported to have suffered sexual abuse for at least 90 days to see if there are any changes that may suggest possible retaliation is occurring. It is the responsibility of the Assistant Program Director to act promptly to remedy the situation. He will also be provided support by the Human Resources/Business Manager and Executive Director when indicated. The monitoring continues beyond ninety (90) days, if the initial monitoring indicates a continuing need as reported by the Assistant Program Director. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):
In the case of residents, such monitoring shall also include periodic status checks.

The Policy and the interview support that status checks would be initiated with residents where it is warranted. The Retaliation Monitoring form provides for periodic status checks.

Provision (e):
If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

The Policy considers other individuals who cooperate with an investigation if they express fear of retaliation from another resident or staff member. The Assistant Program Director indicated he would also take appropriate measures to protect that individual against retaliation.

Provision (f):
An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The Policy allows for the facility's obligation to terminate, if it is determined that the allegation is unfounded. The interview revealed that this is understood.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation. It is concluded that if the facility were to have an incident of retaliation, the Executive Director/PREA Compliance Manager would employ protection measures and monitor according to the time frames required by the standard.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
PREA Pre-Audit Questionnaire

Interviews:
Executive Director
Clinical Director
Program Nurse

§115.368
Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of §115.342.

The facility practice is that segregated housing or isolation is not used at the facility. However, Policy provides that if a resident is separated from the general population (through the assignment of one-on-one staff supervision) the provision of standard 115.342 must be followed. This means that during the separation period, the resident must have access to daily large muscle activities and legally required educational programming or special education services. Daily visits by mental health and medical personnel must occur. Residents shall also have access to other programs and work opportunities to the extent possible. The Executive Director, clinical staff and observations confirmed segregated housing is not used in this facility.

Conclusion:
Based upon the review and analysis of Policy, interviews, and observations, the Auditor has determined the facility is compliant with this standard regarding post-allegation protective custody.

INVESTIGATIONS

Standard 115.371: Criminal and Administrative Agency Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☐ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☐ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
  ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
  ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Investigation Files

Interviews:
Executive Director
Random Staff

Provision (a):
When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

There are no facility-based investigators. The facility and its parent agency do not have investigators to conduct any type of investigations. The Florida Department of Juvenile Justice, Office of Inspector General (OIG) conducts administrative investigations and allegations that are criminal in nature are investigated by the Broward County Sheriff's Office. The Florida Department of Children and Families are also notified regarding allegations of sexual abuse.

Provision (b) and (c):
Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. **Provision (c):** Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged

victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

There are no facility-based investigators. The facility and its parent agency do not have investigators to conduct any type of investigations. The Florida Department of Juvenile Justice, Office of Inspector General (OIG) conducts administrative investigations and allegations that are criminal in nature are investigated by the Broward County Sheriff's Office. The Florida Department of Children and Families are also notified regarding allegations of sexual abuse.

Provision (d):
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

There are no facility-based investigators. The facility and its parent agency do not have investigators to conduct any type of investigations. The Florida Department of Juvenile Justice, Office of Inspector General (OIG) conducts administrative investigations and allegations that are criminal in nature are investigated by the Broward County Sheriff's Office. The Florida Department of Children and Families are also notified regarding allegations of sexual abuse.

Provision (e):
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The facility and its parent agency do not have investigators to conduct any type of investigations.

Provision (f):
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

The facility and its parent agency do not have investigators to conduct any type of investigations.

Provisions (g) and (h):
Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. **Provision (h):** Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

The facility and its parent agency do not have investigators to conduct any type of investigations.

A review of the administrative investigation revealed a report would include an effort to determine whether staff actions or failures to act contributed to the abuse. All investigations are completed with written reports as referred to in the provisions and include a description of the evidence and investigative facts and findings.

Provision (i):
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

The Policy provides that all criminal investigations are referred to the local law enforcement which has the responsibility to refer for prosecution.

Provision (j):
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

The facility retains records while the abuser is incarcerated in, or employed by the facility, plus five years, according to the FDJJ Policy.

Provision (k):
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

The facility and its parent agency do not have investigators to conduct any type of investigations.

Provision (l):
Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

The investigative agencies are aware of the PREA standards requirements. A PREA Compliance sheet is provided by the facility to the investigative agency.

Provision (m):
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

A review of the investigation report and interviews revealed the Executive Director remains abreast of the progress of the investigation, in accordance with Policy. Additionally, the Policy provides that staff shall cooperate with any investigators.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ Policy 1919
Investigation File

Interview:
Executive Director

§115.372
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The Policies state no standard higher than a preponderance of the evidence shall be imposed in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Conclusion:
Based upon the review of the Policies, interview and review of the investigation report, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative investigations.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
Youth Notification Letter

Interviews:
Executive Director/PREA Compliance Manager
FDJJ PREA Coordinator

Provision (a):
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

The Policy addresses the resident being informed when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The Executive Director and the Assistant Program Director remain abreast of an investigation conducted by any of the investigative entities. The Executive Director serves as the primary contact with the Assistant Program Director serving as designee. The notification letter is signed and discussed with the resident by the Executive Director as determined by interview and review of the letter.

Provision (b):
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The Executive Director remains abreast of the investigations and maintains contact with and contact information of the assigned investigator. The notification letter to the resident is signed by the Executive Director.

Provision (c):
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or

(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The Policy requires the following information be provided to the resident when a staff member committed sexual abuse against the resident, unless it has been determined that the allegation is unfounded, whenever:

a. The staff member is no longer assigned within the resident's housing unit;
b. The staff member is no longer employed at the facility;
c. The staff member has been indicted on a charge related to sexual abuse within the facility; or
d. The staff member has been convicted on a charge related to sexual abuse within the facility.

Provision (d):
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The Policy provides that following a resident's allegation that he has been sexually abused by another resident, the alleged victim shall be subsequently informed whenever:

a. The alleged abuser is criminally charged related to the sexual abuse; or
b. The alleged abuser is adjudicated on a charge related to sexual abuse.

Provision (e):
All such notifications or attempted notifications shall be documented.

The Policy provides that all such notifications or attempted notifications be documented. A form, as an extension of the notification letter is used for this purpose.

Provision (f):
An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Policy provides the facility's obligation to report under this standard terminates if the resident is released from the facility's custody.

Conclusion:
The interviews with the identified staff confirmed the Policy requirements and their knowledge of the process of reporting to a resident regarding the outcome of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to residents.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☐ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26

Interview:

Executive Director

Provision (a):
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Policy provides that staff be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies.

Provision (b):
Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse.

The facility Policy provides that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident.

Provision (c):
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Policy and practice provides that disciplinary sanctions for violations of policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Provision (d):
All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Policy provides that terminations for violations of the facility's sexual abuse or sexual harassment policies, or staff resignations related to violations of this policy, shall be reported to law enforcement, unless the activity is clearly not criminal. In addition, it shall be reported to relevant licensing bodies. According to the Executive Director, no staff member has been terminated for violating agency sexual abuse or sexual harassment policies.

Conclusion:
Based upon the review of Policy and interviews, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ-1919

Interviews:
Human Resources/Business Manager
Executive Director

Provision (a):
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The Policies provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies. Training records revealed the facility provides volunteers and contractors a clear understanding that sexual misconduct with a resident is prohibited. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Provision (b):
The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The facility will take the appropriate remedial measures, and consider whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by a contractor or volunteer, as inferred by interviews and Policy.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding corrective action for contractors and volunteers.

Standard 115.378: Interventions and Disciplinary Sanctions for Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Document Reviewed:
Facility Policy 1.26
Youth Handbook

Interviews:
Executive Director
Clinical Director

Provision (a):
A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

The Policy and Youth Handbook address an administrative process for dealing with rule violations and disciplinary sanctions pursuant to a hearing. Sanctions are directly related to the seriousness of the negative behavior. The interview with the Executive Director revealed the process regarding allegations of resident-on-resident abuse. There was one allegation of sexual abuse during the past 12 months.

Provision (b):
Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

Policy considers that disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the extreme event a disciplinary sanction results in the isolation of a resident, the facility shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Isolation is not used in the facility.

Provision (c):
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The Policy provides that the disciplinary and other processes consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. This was confirmed by the interviews with the Executive Director and Clinical Director.

Provision (d):
If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

The facility would consider whether to offer the offending resident therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse participation, based on policy and interview with the Clinical Director. The facility may require participation in such interventions as a condition of access to privileges, but not as a condition to access to general programming or education.

Provision (e):
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Policy provides the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Provision (f):
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The practice is that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred does not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Provision (g):
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Referrals are made to the Broward County Sheriff's Office and court processes occur after determination the sexual activity was coerced.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding interventions and disciplinary sanctions for residents.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26

Interviews:
Case Manager/Staff Responsible for Risk Screening
Program Nurse
Clinical Director

Provision (a) and (b):
If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. **Provision (b):** If the screening pursuant to § 115.341 indicates that a resident

has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

The Policy provides that a resident who indicates during initial screening that they were a victim or perpetrator of sexual abuse shall be offered a follow-up visit with medical or mental health staff within 14 days of the intake screening. This information was also confirmed through the interview with the mental health staff member interviewed.

Provision (c):
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

The Policy supports that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. The Auditor observed the resident files maintained in a secure manner.

Provision (d):
Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

The Policy and interviews provide that medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding medical and mental health screenings; and history of sexual abuse.

Standard 115.382: Access to Emergency Medical and Mental Health Services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.26

Interviews:
Medical Staff
Mental Health Staff
Executive Director

Provision (a):
Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

Policy provides the victim receives timely and unimpeded access to emergency medical treatment, crisis intervention services and advocacy services. The victim would be transported to the Nancy J. Cotterman Center for a forensic examination, at no cost to the victim. The Policy and interviews with the Clinical Director and Program Nurse revealed the medical and mental health services are determined according to the professional judgment of the practitioner.

Residents are informed of clinical services during intake. The residents have access to request forms on their living units. Residents are provided access to an outside victim advocacy agency for services through the Nancy J. Cotterman Center which includes but is not limited to emotional support and accompaniment through the forensic examination and investigative interviews. Observations and a review of documents revealed that medical and mental health staff members maintain secondary materials and documentation of resident encounters. There have been no incidents of sexual abuse during this audit period.

Provision (b):
If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners.

The interviews with clinical staff revealed residents have access to unimpeded access to emergency services. The Policy and the written coordinated response plan flow chart provide guidance to staff in protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. Review of the coordinated plan; observations of the interactions among residents, medical and mental health practitioners; and staff interviews indicated unimpeded medical and crisis intervention services will be available to a victim of sexual abuse.

Provision (c):
Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The Policy and interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate. Additionally, follow-up services as needed will be provided by the facility's medical and mental health staff, according to the interviews with clinical staff. The facility houses males only.

Provision (d):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The Policy states treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser, or cooperates with any investigation arising out of the incident. This was also confirmed through staff interviews.

Conclusion:
Agency Policy revealed emergency services will be provided by medical and mental health staff. The medical and mental health staff interviews revealed they are knowledgeable of actions to take regarding an incident of sexual abuse. It is documented through Policy and understood by the medical and mental health staff that treatment services will be provided at no cost to the victim. Based upon the

review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding access to emergency medical and mental health services.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26

Interviews:
Medical Staff
Mental Health Staff
Executive Director

Provision (a):
The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The Policy requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. According to the interviews, medical and mental health staff members are aware of the Policy requirement. The Policy and interviews support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate.

Provision (b):
The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services and therapy.

Provision (c):
The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Staff interviews and observations revealed medical and mental health services are consistent with the community level of care.

Provision (d):
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

The facility does not house female residents.

Provision (e):
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

The facility does not house female residents.

Provision (f):
Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Follow-up services will be conducted at the facility, as needed, based on policies and the interviews.

Provision (g):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

All treatment services will be provided at no cost to the victim, according to Policy and staff interviews.

Provision (h):
The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

The mental health staff interview supported that attempts are to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the screening instrument if the offense occurred in this facility.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386 (d) (1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ Policy 1919
Interoffice Memorandum

Interviews:
Executive Director
Assistant Program Director
FDJJ PREA Coordinator

Provision (a):
The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

The facility Policy requires the facility to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been deemed to be unfounded. A review of the Policy and interviews confirmed knowledge of the function of the incident review team. The one allegation received an administrative and criminal investigation and was determined not to be an alleged criminal act and unfounded, therefore not requiring an incident review. The Interoffice Memorandum from the FDJJ Assistant Secretary of Residential Services outlines the requirements of the incident review team process and mandates its occurrence.

Provision (b):
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

The Policies require that the reviews occur within 30 days of the conclusion of the investigation which is also the practice. The administrators confirmed incident reviews would occur within 30 days of the

conclusion of an investigation in accordance with agency Policy and the standard. The interviews confirmed the Policies.

Provision (c):
The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The facility Policy identifies the incident review team members as administrative staff, medical staff, mental health staff, input from line supervisors and investigators, when investigated by the OIG. Sequel Youth and Family Services regional staff may also participate in the incident review process. The FDJJ PREA Coordinator facilitates the meeting regarding the incident review team. The interviews were aligned with the Policy.

Provision (d):
The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interviews and review of Policies confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation, including:

- considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex;
- other group dynamics;
- assessment of the area relative to the allegations; and
- adequacy of staffing.

The Policy requires the meeting to be documented, including recommendations and the document provided to the Executive Director. The interviews with the Executive Director and FDJJ PREA Coordinator and review of the Interoffice Memo confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. The interviews also confirmed that the team would consider all factors required by the standard. The incident review team meeting is facilitated by the FDJJ PREA Coordinator.

Provision (e):
The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

Policy provides the administration will implement the recommendations for improvement, or will document its reasons for not doing so. The Executive Director and Assistant Program Director are familiar with this Policy requirement. The format of the documented meeting has been developed by the FDJJ PREA Coordinator and provides for the record keeping of the incident review team meeting. The format allows for documentation of the considerations of the standard. Additionally, recommendations for improvement by the team members will be incorporated in the document.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding the sexual abuse incident review team.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ Policy 2020, Incident Operations Center and Management Reviews
Aggregated Data Reports
FDJJ Annual Report
FDJJ Central Communications Center Classification (CCC) Definition Report

Interviews:
Executive Director
FDJJ PREA Coordinator

Provisions (a) & (c):
The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The Policies require the use of a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual abuse. A review of the resulting reports through the collection of data per facility and the facility's data collection and maintenance demonstrates the inclusion of data to answer the Survey of Sexual Violence conducted by the U. S. Department of Justice.

Provision (b):
The agency shall aggregate the incident-based sexual abuse data at least annually.

The Policies and review of the annual report and data gathering instruments and other documents and the interviews confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment for each facility. A standardized instrument and specific guidelines and definitions, FDJJ CCC Classification Definition Report, is used to assist in identifying the data.

Provision (d):
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility maintains and collects various types of identified data and related documents regarding PREA and provides the information to FDJJ. The facility collects and maintains data in accordance with facility and FDJJ Policy directives. The FDJJ aggregates the data which culminates into an annual report.

Provision (e):
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

The FDJJ maintains and aggregates data from every state operated and private facility it contracts with for the confinement of its residents as confirmed by the FDJJ PREA Coordinator through the interview regarding data and the data collection process.

Provision (f):
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Policy states that upon request, the facility will provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ Policy 1919
Aggregated PREA Data Reports
Annual Report

Interviews:
Executive Director
FDJJ PREA Coordinator

The Policy supports the review of data collected and aggregated in order to improve the PREA efforts. The interviews revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews supported the provisions of the collective Policies and the standard.

The Policies indicate an annual report will be prepared that will provide information regarding corrective actions in addressing sexual abuse. The annual report, prepared by FDJJ, is approved by the FDJJ Secretary as required by Policy, per the interviews and a review of the report. The annual report reflects a comparison of the results of annual data. The annual report has been reviewed and the report is accessible to the public through the FDJJ website and dissemination. There are no personal identifiers in the annual report.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy 1.26
FDJJ Policy 1919
Annual Report

Interview:
Executive Director

Policies 1.26 and 1919 indicate that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to the Policies, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the FDJJ website. A review of the annual report verified there are no personal identifiers. Related documentation in the facility was observed to be securely stored.

Conclusion:
Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the

agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

PREA audits for the facility have been conducted as required for the initial three-year period. The agency is fulfilling the auditing requirements for this second three-year period. The facility has provided the Auditor with the required documentation as required by the standards and the auditing process. A comprehensive site review was provided to the Auditors during the site visit and additional

documentation was reviewed during the site visit. The staff members were cooperative in providing additional documentation as requested.

The Executive Director provided appropriate work spaces which included conditions for conducting interviews in private with the residents and staff. The posted notices regarding the audit were observed throughout the facility, accessible to residents; staff; visitors; contractors; and volunteers. The notices provided directions and contact information informing those who wanted to contact the Auditor of how to do so. No correspondence was received by the Auditor.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This facility was previously audited in 2015 and the Auditor confirmed the audit report was posted on the FDJJ website as is the practice. The report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation; interviews with staff, residents, volunteers, contractors, and observations.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Shirley L. Turner — September 20, 2018

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.