# A PREA AUDIT: AUDITOR'S SUMMARY

# REPORT JUVENILE FACILITIES

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| **Name of Facility: Marion Youth Academy** | | | | |
| **Physical Address: 10420 NW Gainesville Rd., Ocala, FL 34482** | | | | |
| **Date report submitted: March 24, 2015** | | | | |
| **Auditor information: Shirley L. Turner** | | | | |
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| **Telephone number: 678-895-2829** | | | | |
| **Date of facility visit: March 11-12, 2015** | | | | |
| **Facility Information** | | | | |
| **Facility Mailing Address: 10420 NW Gainesville Rd., Ocala, FL 34482** | | | | |
| **Telephone Number: (352) 840-8240** | | | | |
| **The Facility is:** | ☐Military | ☐County | ☐Federal | |
| | ☒Private for profit | ☐Municipal | ☐State | |
| | ☐Private not for profit | | | |
| **Facility Type:** | ☐Detention | ☒ Correction | ☐Other: | |
| **Name of PREA Compliance Manager: Keenan Bullard** | | | **Title:** | **Facility Administrator** |
| **Email Address: Keenan.Bullard@youthservices.com** | | | **Telephone Number:** | **(352) 840-8240** |
| **Agency Information** | | | | |
| **Name of Agency: Youth Services International, Inc.** | | | | |
| **Governing Authority or Parent Agency: NA** | | | | |
| **Physical Address: 6000 Cattle Ridge Dr., Suite 200, Sarasota, FL 34232** | | | | |
| **Mailing Address: Same as Above** | | | | |
| **Telephone Number: (941) 953-9199** | | | | |
| **Agency Chief Executive Officer** | | | | |
| **Name: James Slattery** | | | **Title:** | **President & Chief Executive Officer** |
| **Email Address: Jim.Slattery@ysii.com** | | | **Telephone Number:** | **(941) 9533-9199** |
| **Agency Wide PREA Coordinator** | | | | |
| **Name: Jesse Williams** | | | **Title:** | **PREA Coordinator** |
| **Email Address: Jesse.Williams@youthservices.com** | | | **Telephone Number:** | **(941) 704-8796** |

# AUDIT FINDINGS

## NARRATIVE:

The Marion Youth Academy is located in Ocala, Florida and is a 42-bed moderate risk facility that houses male juvenile offenders that range from ages 14 to 18. The facility is operated by Youth Services International, Inc. (YSI) through a contract with the Florida Department of Juvenile Justice (DJJ). The average length of stay is 10 months. During their stay in the facility, residents participate in a daily schedule that includes education/vocational classes; case management services; mental health services; and recreation. At least ninety-two residents have been admitted to the facility during the past 12 months.

The number of staff currently employed at the facility who may have contact with the residents is 43. Medical services are provided on-site by a full-time Registered Nurse who serves in the position of Lead Nurse and a full-time Licensed Practical Nurse. The contract physician visits the facility on a weekly basis. Mental health staff includes the Clinical Director and three Therapists. The position of the Clinical Director is currently vacant and the role is being temporarily filled by qualified staff from other areas in the capacity of Acting Clinical Director. A contract psychiatrist visits the facility twice a month. Case management services are provided by two Case Managers, supervised by the Case Manager Supervisor. Education services are provided on-site by contract staff through the Marion County Public Schools. Youth Care Workers and Supervisors provide supervision and oversight of residents during their involvement in activities on and off facility grounds and throughout the residents' movement within the facility.

An individualized treatment plan is completed for each resident and a monthly review of each resident's treatment plan is conducted. Parents/legal guardians are invited and encouraged to take an active part in the review as well as to be supportive to their child in his efforts to achieve his treatment goals. The facility conducts Family Day on a quarterly basis and parents/legal guardians are invited to spend the afternoon with their son and eat lunch with him. During Family Day, treatment staff is also available to interact with parents/guardians and discuss each resident's treatment and progress in the program. A behavior management system exists for the residents that supports accountability and provides for consequences when the program rules and expectations are not followed.

## DESCRIPTION OF FACILITY CHARACTERISTICS:

The entrance to the building contains the control room and administrative offices are located in the front area of the building. Through the adjacent doorways are the kitchen; dining area; and two wings, Phase I and Phase II. Ten rooms are located on Phase I that houses two residents; 13 rooms are on the Phase II wing where two are single rooms and 11 rooms that house two residents each. Each Phase or wing contains a dayroom; inside recreation court or the basketball court; a laundry

room and classrooms. The section of the building beyond the main doorways also contains additional offices, medical clinic, library; conference room; maintenance office; and storage closets. Phase I and Phase II have bathrooms that afford residents a reasonable amount of privacy while they shower, change clothes and perform bodily functions.

A garden is maintained outside in the back of the building. The garden serves as an educational activity for residents as well as an opportunity in life skills and a positive behavior incentive. The residents tend to the garden and consume its contents under the supervision of one of the teachers. The outside grounds contain ample space for recreation and other activities, as well as the garden.

## SUMMARY OF AUDIT FINDINGS:

The process began with a conference call which included the Facility Administrator, PREA Auditor and other YSI and DJJ staff to discuss the audit process. The notifications of the on-site audit were later posted in various parts of the facility prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. After reviewing the information on the flash drive, a follow-up call was made to the Facility Administrator to discuss data and for clarification of information. Additional information was provided or clarified as requested.

The on-site audit was conducted March 11-12, 2015. An entrance meeting was held with the Facility Administrator and afterwards, a comprehensive tour of the facility was conducted by the Facility Administrator. This Auditor observed staff members directly supervising and interacting with the residents. The interviews conducted included random staff, specialized staff and residents.

PREA file folders were set up in a very neat and organized manner that contained supplemental documentation. A close-out meeting was held at the conclusion of the on-site audit and a summary of the audit findings was provided to the Facility Administrator, Assistant Facility Administrator and the YSI PREA Coordinator participated by telephone.

Number of Standards Exceeded: 0

Number of Standards Met: 38

Number of Standards Not Met: 0

Number of Standards Not Applicable: 3

**Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26, Prison Rape Elimination Act (PREA), provides guidelines for implementing compliance with the requirements of the PREA standards. The Policy provides for zero-tolerance toward all forms of sexual abuse and sexual harassment. The Policy contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. The Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919) is used as the overarching Policy that must be adhered to.

**Standard 115.312 Contract With Other Entities for the Confinement of Residents.**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

**Auditor Comments:**

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

**Standard 115.313 Supervision and Monitoring**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse and refers to the current staffing assignments per the current contract. The operational work schedules and a hold-over system are implemented to maintain the required staff ratios during the awake and sleeping hours. The annual assessment of the staffing plan has been conducted and documented.

Unannounced rounds of the facility for the maintenance of a safe environment are conducted and documented by the appropriate staff, including the Facility Administrator. The Policy and

facility's practice prohibit staff from alerting other staff while the unannounced rounds are being conducted. Staff interviews and a review of documentation, including the camera system, confirmed the practice of unannounced rounds being conducted.

**Standard 115.315 Limits to Cross-Gender Viewing and Searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, cross-gender pat-down searches, cross-gender strip searches and cross-gender visual body cavity searches of residents are prohibited, except in exigent circumstances or when performed by medical practitioners. In the event of any occurrence, documentation of the situation is required. According to the staff interviews, the facility practice is that no type of cross-gender searches should occur. All of the residents interviewed stated that they have not been searched by a female staff member during their stay at the facility.

The PREA Policy, 1.26, provides for residents to shower, perform bodily functions, and change clothes without being observed by staff of the opposite gender. Interviews with staff and residents confirm these practices. Policy 1.26 states that staff shall not search a transgender or intersex resident to determine the resident's genital status and all staff interviewed were aware of the facility policy. Additionally, the Policy directs staff to ask a transgender or intersex resident which gender they would prefer to conduct the search.

**Standard 115.316 Residents With Disabilities and Residents Who are Limited English Proficient**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, support services are provided for residents with disabilities and residents who are limited English proficient so that they may benefit from and participate in PREA education. Resident education materials are accessible in languages other than English. Policy 1.26 states that the facility will not rely on resident interpreters or resident readers to provide information to other residents. The Policy provides for the use of outside resources and the services of the education and mental health units. A review of the documentation provided and staff interviews confirmed that residents are not to be used as interpreters or readers to assist other residents.

**Standard 115.317 Hiring and Promotion Decisions**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and Florida DJJ Policy 1919 provide for background checks on all employees, contractors and volunteers through a process that meets the requirements of the standard and used statewide. Related documentation and staff interviews revealed that prior to the hiring of an employee or contractor or the use of a volunteer's services, background checks are conducted. The facility's PREA Policy and DJJ 1919 require that criminal background checks be conducted every five years on employees and on contractors who may have contact with residents.

**Standard 115.318 Upgrades to Facilities and Technology**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

**Auditor Comments:**

This standard is not applicable. The facility reports that there has not been a substantial expansion or modification to the facility and the camera system has not been updated during the time period since August 20, 2012.

**Standard 115.321 Evidence Protocol and Forensic Medical Examinations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 states that staff will cooperate in investigations conducted by the FDJJ Office of the Inspector General (OIG). The OIG is responsible for administrative investigations and investigations are conducted by the Florida Department of Children and Families (DCF) and local law enforcement. Policy 1.26 further states that forensic medical examinations will be completed at no financial cost to the victim. The facility provided documentation of efforts to obtain advocacy services that would be accessible to the residents, if needed .

**Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 require that staff report all allegations of sexual abuse and sexual harassment. There has been one allegation from a resident during this audit period. The allegation was reported as required and investigated by the Marion County Sheriff's Office and the OIG. The findings of the report from the Sheriff's Office stated that the case was closed as Unfounded. The administrative investigation findings by the OIG stated that the case was Closed as Information Only regarding the allegations. Concerning staff, the OIG investigation resulted in findings that caused the Facility Administrator to provide additional specific training for staff.

The facility posts related information regarding reporting allegations of sexual abuse and sexual harassment in areas which are accessible to the public. The DJJ website contains information regarding the referral of allegations for investigations of sexual abuse.

**Standard 115.331 Employee Training**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 provides for the PREA training of all staff. The facility staff received the DJJ training and the facility has conducted refresher training in the key areas referenced in the standards. Documentation of staff participating in training is maintained and staff interviews confirmed that training occurs.

**Standard 115. 332 Volunteer and Contractor Training**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 contains information regarding the training of volunteers and contractors who have contact with residents. Receipt of the training is documented and the training contains a review of the PREA Policy.

**Standard 115.333 Resident Education**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Resident education is provided to residents as confirmed by interviews with residents and staff and a review of documents. Residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. As determined through resources identified in Policy 1.26, a review of other documentation and staff interviews, the facility will provide support services in accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled.

**Standard 115.334 Specialized Training: Investigations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

FDJJ 1919 states that investigators in the OIG will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Training is provided to investigative staff regarding conducting investigations in the DJJ settings.

**Standard 115.335 Specialized Training: Medical and Mental Health Care**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 addresses PREA training for medical and mental health staff. A review of documentation and staff interviews confirmed the specialized training for medical and mental health staff. Forensic medical examinations are not conducted by the facility medical staff.

**Standard 115.341 Screening for Risk of Victimization and Abusiveness**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

The initial risk screening is conducted during the intake process. Policy 1.26 and staff interviews provide for residents to receive reassessments within the first 30 days. After that period, they are conducted periodically through the treatment team process. A review of documentation and staff and resident interviews confirmed that the risk screening is being conducted on each admission to the facility.

**Standard 115.342 Use of Screening Information**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, the facility prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Policy 1.26 states that housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. Additionally, Policy 1.26 prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The facility reports that during this audit period there have been no residents placed in isolation because of being at risk for victimization. Policy 1.26 provides that residents may be isolated from others only as a last resort when less restrictive measures are inadequate and until other arrangements can be made to keep the resident safe. Where isolation may be used, Policy 1.26 provides that residents receive the required services.

**Standard 115.351 Resident Reporting**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 states and staff and resident interviews confirmed that there are internal ways a resident may report. A "Speak Out Form" may be completed where the resident states what

they would like to discuss with a specific staff member identified on the Form; complete a grievance form; talk to any staff member; and third parties may report allegations to staff. The grievance and other written requests may be placed in the locked grievance box. PREA related information is posted in various locations. Residents are provided access to a telephone to report allegations of sexual abuse and sexual harassment to the abuse reporting hotline.

Interviews revealed that staff members are aware of their responsibility to report any allegations or suspicions of sexual abuse or sexual harassment. Staff members are also aware of their responsibility to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties as stated in Policy 1.26 and FDJJ 1919. Staff members are directed to immediately document verbal reports.

**Standard 115.352 Exhaustion of Administrative Remedies**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Residents may put a completed grievance form in the grievance box. Residents are not required to use an informal grievance process regarding allegations of sexual abuse and sexual harassment. The facility considers an emergency grievance as a resident's allegation and when one is received, Policy 1.26 provides for the implementation of the procedures for reporting allegations of sexual abuse and sexual harassment to be initiated.

**Standard 115.353 Resident Access to Outside Confidential Support Services**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 requires the facility to provide the residents with access to outside victim advocacy services. The facility has provided documentation of their continued efforts to obtain victim advocacy services for residents when needed.

Visitation is held at the facility at least weekly where residents may see their parents/guardians and the residents are allowed to make weekly telephone calls. Family Day is held quarterly at the facility where the parents/guardians may share lunch and spend the afternoon together. Attorneys or other legal representation may visit the facility and these visits may be conducted in a confidential manner.

**Standard 115.354 Third-Party Reporting**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 provides guidelines regarding third-party reporting. Information about reporting incidents of sexual abuse is posted in the facility, accessible to the public. Staff and resident interviews confirmed that the facility has a method for third-party reporting. The YSI website contains a link to the DJJ website which provides information on how to report resident sexual abuse or sexual harassment.

**Standard 115.361 Staff and Agency Reporting Duties**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and Florida Statute directs that all staff members are mandated reporters. Staff should immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment; retaliation against residents or staff who report any incidents; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy 1.26 prohibits staff from sharing information regarding sexual abuse other than as needed to make treatment, investigation, and other security and management decisions. The interviews conducted with staff confirmed their knowledge of this information.

**Standard 115.362 Agency Protection Duties**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, when a staff member learns that a resident is subject to substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident. The facility reports that there have been no incidents in the last 12 months where any action was taken regarding a resident being in substantial risk of imminent sexual abuse. Interviews with staff revealed the protective measures that may be taken when a resident is at risk.

**Standard 115.363 Reporting to Other Confinement Facilities**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Facility Administrator (FA) will notify the Central Communications Center (CCC) of the allegation within two hours. The Policy also provides that the FA will notify the facility of which the allegation was made, no later than 24 hours.

**Standard 115.364 Staff First Responder Duties**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 provides an account of first responder duties and responses. There has been one allegation by a resident regarding sexual abuse within the last 12 months which was reported as required. The allegations were investigated by the Marion County Sheriff's Office and the OIG and both investigations have been closed.

**Standard 115.365 Coordinated Response**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

The facility has a written Coordinated Response Plan. A review of training records and interviews with staff confirmed the staff's knowledge of their responsibilities. The Plan outlines the actions to be taken among staff including first responders, leadership, medical and mental health in response to an incident of sexual abuse.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒Standard Not Applicable

**Auditor Comments:**

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

**Standard 115.367 Agency Protection Against Retaliation**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Directions are provided in Policy 1.26 regarding protection against retaliation for residents and staff who report allegations of sexual abuse or sexual harassment. Staff has been identified and given the responsibility of monitoring for possible retaliation. If the conduct of retaliation is identified, the facility practice is that the monitoring is ongoing. The facility reports that no incidents of retaliation have occurred during the past 12 months.

**Standard 115.368 Post Allegation Protective Custody**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 ensures that if there is any use of segregated housing or isolation, it is used as a last resort and that the resident is afforded access to the required program and services provided by the facility. Staff interviews supported that a resident placed in isolation will receive programming and services as required.

**Standard 115.371 Criminal and Administrative Agency Investigations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 address this standard. Administrative investigations are conducted by OIG and criminal investigations are conducted by DCF and local law enforcement. Both Policies direct facility staff to cooperate with the OIG investigations. The Policies provide for substantiated allegations of conduct that appear to be criminal to be referred for prosecution. A Memorandum of Understanding exists between the facility and the Marion County Sheriff's Office.

**Standard 115.372 Evidentiary Standards for Administrative Investigations**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

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

**Standard 115.373 Reporting to Residents**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 provide for notifying residents following an investigation of whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Policies require that all notifications or attempted notifications be documented.

**Standard 115.376 Disciplinary Sanctions for Staff**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 provide for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. Both Policies require that staff terminations or resignations by staff who would have been

terminated for violating the PREA Policies, be reported to local law enforcement and to relevant licensing bodies. No staff has been terminated or has resigned for violating PREA related policies during this audit period.

**Standard 115.377 Corrective Action for Contractors and Volunteers**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, the contractor or volunteer who engages in sexual abuse will have no contact with residents and will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The Policy requires that remedial measures be taken and prohibits future contact with residents in the case of any other violation of the PREA related policies. The facility reports that during the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

**Standard 115.378 Disciplinary Sanctions for Residents**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 provides for a resident who engages in resident-on-resident sexual abuse to be placed in a DJJ Juvenile Detention Center. The resident will receive the required court hearings and a determination will be made regarding the subsequent placement.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be referred for a follow-up meeting with a medical or mental health practitioner within 24 hours of the screening. Staff interviewed confirmed awareness of the policy and explained the practice regarding mental health and medical screenings.

**Standard 115.382 Access to Emergency Medical and Mental Health Services**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 provides for timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse. According to Policy 1.26 and staff interviews, the nature and scope of the services are determined by medical and mental health practitioners based on their professional judgment. Staff interviews and Policy 1.26 provide for emergency medical and mental health services to be provided at no financial cost to the victim and whether or not the abuser is named.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, ongoing medical and mental health care for sexual abuse victims is provided. It also provides for medical and mental health evaluations and appropriate treatment and follow-up services as referred to in the standard. Policy 1.26 and staff interviews agree that the medical and mental health services provided are consistent with the community level of care.

**Standard 115.386 Sexual Abuse Incident Reviews**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 will serve as the guide for staff in conducting incident reviews. The incident review team has been identified and interviews revealed an understanding of the purpose of the process.

**Standard 115.387 Data collection**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

According to Policy 1.26, the facility reports data to DJJ on a monthly basis. Additionally, Policy 1.26 and FDJJ 1919 state that there is the collection of accurate, uniform data for every allegation of sexual assault. The DJJ has developed a data collection instrument that includes the required data.

**Standard 115.388 Data Review for Corrective Action**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policy 1.26 and FDJJ 1919 address this standard. The Policies require the review of data for corrective action towards improving the effectiveness of the agencies' prevention, protection and response policies, practices, and training regarding sexual abuse and sexual harassment.

**Standard 115.389 Data Storage, Publication and Destruction**

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

**Auditor Comments:**

Policies 1.26 and FDJJ 1919 require that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed, all personal identifiers are removed, and the information is posted on the DJJ website.

**AUDITOR CERTIFICATION:**

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

Shirley L. Turner — March 24, 2015

Auditor Signature — Date