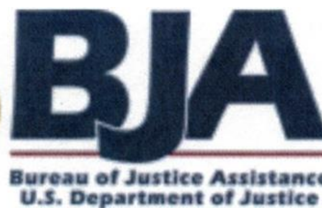
PREA AUDIT: AUDITOR'S SUMMARY REPORT JUVENILE FACILITIES



Name of Facility: Okaloosa Youth Academy			
Physical Address: 4455 Straight Line Road, Crestview, FL 32539			
Date report submitted: December 17, 2014			
Auditor information: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: November 17-18, 2014			
Facility Information			
Facility Mailing Address: 4455 Straight Line Road, Crestview, FL 32539			
Telephone Number: (850) 689-1984			
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: Denny Skinner		**Title:**	QA Officer
Email Address: denny.skinner@uhsinc.com		**Telephone Number:**	(850) 683-3900
Agency Information			
Name of Agency: Gulf Coast Youth Services, Inc.			
Governing Authority or Parent Agency: Universal Health Services			
Physical Address of Agency: 1015 Mar Walt Drive, Fort Walton Beach, FL 32547			
Mailing Address: Same as Above			
Telephone Number: (850) 863-4160			
Agency Chief Executive Officer			
Name: Jeanette Jackson		**Title:**	Chief Executive Officer
Email Address: jeanette.jackson@uhsinc.com		**Telephone Number:**	(850) 863-4160
Agency Wide PREA Coordinator			
Name: Denny Skinner		**Title:**	QA Officer
Email Address: denny.skinner@uhsinc.com		**Telephone Number:**	(850) 683-3900

AUDIT FINDINGS

NARRATIVE:

The Okaloosa Youth Academy, located in Crestview, Florida, is a 75 bed moderate risk residential facility that houses male juvenile offenders in the age range of 10-19. The facility is operated by Universal Health Services, Inc. through a contract with the Florida Department of Juvenile Justice (DJJ). Thirty-five beds are allotted for youth who have been adjudicated as sex offenders. Forty beds are allotted for adjudicated youth identified as moderate risk and 10 of those beds are for youth with substance abuse issues. The average length of stay for the sex offender program and the substance abuse program is 12-18 months and 6-9 months for the remaining youth. While in the facility residents participate in programming that include education and vocational services; social services; mental health services; substances abuse services; recreation; transition planning; and faith based services provided by volunteers. Seventy-seven residents have been admitted to the facility in the past 12 months.

One hundred thirteen staff members have been employed at the facility during the past year. On-site medical services, including an evaluation and screening for any medical needs, are provided by a full-time Registered Nurse and two Licensed Practical Nurses. The contract physician visits the facility weekly. Mental health services are provided on-site by the Treatment Coordinator and six Therapists, with a contract psychiatrist visiting twice a month. The parent agency has a Director of Nursing and a Designated Mental Health Authority on staff and they are accessible to the facility medical and mental health personnel. Education services are provided by teachers through the Okaloosa County School District. Case Managers ensure coordinated efforts for individualized treatment; transition planning begins at the time of admission.

The Okaloosa Youth Academy program is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The goals of the facility are to develop and broaden the skills of the residents through therapeutic and rehabilitative programming enabling residents to meet their individualized goals; and to assist residents in establishing and maintaining useful interactions and relationships that transcend to a successful re-entry into the community.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is located approximately two miles south of Crestview, Florida in an area with other adult and juvenile correctional facilities and a juvenile detention center. The program consists of an administration building; housing units; a building that contains the kitchen and dining area on one side and the education unit of four classrooms on the other. There is a vocational building where instructors through Home Builders Institute conduct classes and hands-on activities in woodworking, basic home maintenance and carpentry. A computer laboratory is also housed in the vocational building. One of the housing units houses the colorfully themed painted Reward Area which consists of the token store; game rooms; area to watch movies; library/quiet room; and a barber shop. There is ample space on the outside grounds for an array of recreation and other activities.

A dayroom is located in each housing unit along with showers, toilets, and a laundry room. The bathrooms provide reasonable privacy for the residents. Each housing unit has a tranquility room that contains books and a chalkboard. The facility grounds accommodate a chicken pen and several chickens in a fenced area. Under staff guidance, the youth take responsibility in caring for the chickens and gathering the eggs. The care of the chickens serves a therapeutic purpose as well as educational and vocational opportunities for the residents. Youth Care Workers provide direct supervision of residents in daily activities and movement to and from activities and services both inside and outside of the facility.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility at least six weeks prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. An initial call was made to the Program Director to discuss the process and for clarification of information. 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 written response was sent to the PREA Coordinator and followed up with a telephone call. Additional information was provided or clarified as requested. The parent agency's Quality Assurance (QA) Officer serves as the PREA Coordinator.

The on-site audit was conducted November 17-18, 2014. An entrance meeting was held with the Program Director, Assistant Program Director and the QA Officer/PREA Coordinator. After the meeting a comprehensive tour of the facility was conducted by the Program Director and the Assistant Program Director. During the tour, staff members were observed to be directly supervising the residents. Random staff, specialized staff and residents were interviewed during the on-site audit process.

While on-site, additional information for the audit process was provided in a prompt manner. 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 Program Director and the PREA Coordinator.

Number of Standards Exceeded: 0

Number of Standards Met: 39

Number of Standards Not Met: 0

Number of Standards Not Applicable: 2

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The facility has various policies that provide guidelines for implementing the agency's approach to complying with the requirements of the PREA standards. Policy 13.00 states a 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 also used and adhered to for support of the PREA standards.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

X 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)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.010 provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse and that the ratios are aligned with the program contract. The facility reported no deviations from the current staffing plan in the past 12 months. The annual assessment of the staffing plan and other areas has been conducted to determine whether adjustments are needed in accordance with the standard. A review of the staffing has been documented through the completion of the Staffing Plan Assessment form.
Unannounced rounds of the facility for the maintenance of a safe environment are conducted and documented by appropriate staff. Staff interviews and a review of documentation confirmed the practice of unannounced rounds.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.100 prohibits cross gender pat-down searches and there have been no cross gender pat-down searches during this audit period. The Policy also prohibits staff from conducting cross-gender strip or cross-gender visual body cavity searches of residents and none have been conducted during this audit period. Policies 13.09 and FDJJ 1919 have been implemented that provide 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 the aforementioned practices. Policy 13.11 states that staff shall not search a transgender or intersex resident to determine the resident's genital status. The related training and reviews have been provided.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 1.150 addresses support that provide residents with disabilities and residents who are limited English proficient with various services so that they may benefit from and participate in PREA education. Resident education materials are available in dominant languages other than English. Policy 1.150 ensures that the facility will not rely on resident interpreters. The policy contains information regarding the resources to be used and how they will be accessed. A review of documentation and staff interviews confirmed that outside resources would be used to assist residents.

Standard 115.317 Hiring and Promotion Decisions

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 1.130, FDJJ 1800 and 1919 provides for background checks on all employees and contractors through a process that is aligned with the standard. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

A secondary monitoring system is used in addition to direct staff supervision. A camera system that enables staff to observe activities and areas on multiple screens is used. There are a total of 96 cameras within and outside of the facility. Additional cameras were added in the administration building and in an outside area to aid in the observation of residents. The Program Director has access to the camera system by desktop monitoring of activities from his office.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.18 addresses this standard and states that staff will cooperate in investigations conducted by the FDJJ Office of the Inspector General (OIG) for administrative investigations and with the Florida Department of Children and Families and local law enforcement regarding criminal investigations. Policy 13.13 provides for forensic medical examinations to be completed at no financial cost to the victim. There have been no forensic examinations in the last 12 months. The facility has a Memorandum of Understanding (MOU) with the Shelter House, Inc. in Fort Walton Beach, Florida which provides victim advocacy services that include accompaniment to forensic examinations and training for staff and residents.

Standard 115.322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.27 and FDJJ 1919 provide that staff report all allegations of sexual abuse and sexual harassment. The appropriate investigative entity will be contacted regarding reporting and any subsequent investigation. There has been one allegation from a resident during the past 12 months. The allegation was reported as required and investigated by the Okaloosa County Sheriff's Office, the Department of Children and Families the DJJ OIG. According to the summation at the end of the report by the Sheriff's Office, the case was closed due to no independent witnesses; no further leads to follow; and conflicting statements. The Department of Children and Families closed the case as unsubstantiated. The DJJ website contains information regarding the referral of allegations for investigations of sexual abuse. The facility posts related information in the visitation area which is accessible to the public.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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 standard. Documentation of staff participating in training is maintained.

Standard 115. 332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.04 contains information regarding the training of volunteers and contractors who have contact with residents. Receipt of the training is documented and it contains a review of the agency's zero tolerance policy.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Documentation and interviews with residents and staff confirm that residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. In the past 12 months, approximately 77 residents received the information. Documentation of residents' signatures is maintained to support that residents received the PREA education. Through resources identified in policy, 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 staff in the OIG will be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports. Training is provided to investigative staff regarding conducting investigations in the DJJ settings.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

☒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 13.15 addresses PREA training for medical and mental health staff. A review of documentation and staff interviews confirm the specialized training. The facility nurses do not conduct forensic medical examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:
Policies 13.01 and FDJJ 1919 address this standard. A review of documentation and staff and resident interviews confirm that screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being conducted on each resident. The initial screening is done during the intake process and Policy states that residents receive reassessments periodically.

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:
The facility prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. According to Policy 13.02 housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The facility prohibits considering gay, bisexual, transgender, or intersex

identification or status as an indicator of likelihood of being sexually abusive. Isolation is not used at this facility and there have been no residents placed in isolation because of victimization.

Standard 115.351 Resident Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policy 13.22 and staff and resident interviews, there are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that lead to abuse. A resident may file a grievance; complete a Youth Special Request Form where a resident seeks to talk to specific staff; write a note; 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 box located in the housing units.

PREA related information is posted in each housing unit. Residents are provided access to a telephone to report allegations of sexual abuse and sexual harassment to the abuse reporting hotline. The hotline number is also accessible from any office phone in the administration building. Interviews revealed that staff members are aware of their responsibility to report sexual abuse and sexual harassment. They are also aware that they are to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties in accordance with Policies 13.22 and FDJJ 1919.

Standard 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 13.21 and 3.08 provide guidance regarding the grievance process and information is contained in the resident handbook. Residents may put a completed grievance form in the locked grievance box located in each housing unit. Policy prohibits the use of an informal grievance process regarding allegations of sexual abuse and sexual harassment. The facility reports that there have been no grievances submitted relating to sexual abuse or sexual harassment received in the past 12 months.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.23 requires the facility to provide the residents with access to outside victim advocacy services. The documented MOU provides for services that will be delivered by a local victim advocacy agency. A telephone conversation with the representative from the victim advocacy agency, Shelter House, Inc., confirmed that victim services will be provided to the facility when requested and that no services have been requested.

Residents are allowed to see their parents at visitation on the weekends and they are also allowed to make weekly phone calls. Attorneys or other legal representation may visit the facility and may visit in a confidential manner.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

☒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 13.14 provides guidelines regarding third-party reporting. The DJJ website provides the public with information regarding third-party reporting of abuse. Parents receive information about reporting incidents of sexual abuse through information posted in the visitation area. Staff and resident interviews were aligned with this information.

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:

According to Policy 1.07 and Florida Statute 39.201, all staff members are mandated reporters. They are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment, retaliation against residents or staff who report any incidents or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff interviews support 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:

Policy 13.12 addresses this standard and provides that when the agency or facility staff learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. There have been no incidents in the last 12 months

where the agency or the facility took any action in regards to a resident being in substantial risk of imminent sexual abuse. Policy guides the response to this standard if it becomes necessary.

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 13.26, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Program Director/designee will notify the Central Communications Center (CCC) of the allegation within 72 hours. The CCC notifies the facility of which the allegation was made. Staff interviews confirmed knowledge of the policy and procedure.

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 13.20 addresses the first responder duties and 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 and determined to be unsubstantiated. Staff training and a refresher have been provided, including the duties of the first responder.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

A review of the written document, PREA Institutional Plan, and interviews with staff confirm that a coordinated response plan has been developed. The plan coordinates the actions to be taken among staff including first responders, leadership, medical and mental health staff, 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:

Policy 13.19 addresses protection against retaliation for residents and staff who report allegations of sexual abuse or sexual harassment. The Program Director, Assistant Program Director and shift supervisors have been identified as the staff members designated with monitoring for possible retaliation. If the conduct is identified the Policy states that the monitoring is ongoing. Policy 13.19 also instructs staff on reporting incidents of retaliation.

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 13.29 addresses this standard and covers the requirements of how protective measures are implemented. The protective measures do not include the isolation of residents; however, the resident may be transferred to another room and/or housing unit. The resident will be separated from potential abusers, according to the policy and staff interviews.

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 13.18 and FDJJ 1919 address this standard. Administrative investigations are conducted by the DJJ Office of Inspector General and criminal investigations are conducted

by the Department of Children and Families and local law enforcement. Both Policies direct facility staff to cooperate with the investigations. Policy also provides that an investigation is not terminated solely because the source of the investigation recants the allegation. Substantiated allegations of conduct that appears to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.28 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)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.18 and FDJJ 1919 provide the process for notifying residents following an investigation, of whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.17 and FDJJ 1919 provide for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. The policies require that the violation be reported to local law enforcement and provides for contacting relevant licensing bodies. In the past 12 months, no staff has been terminated or has resigned for violating PREA related policies.

Standard 115.377 Corrective Action for Contractors and Volunteers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.16 and FDJJ 1919 address the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. The incident will be reported as required as well as relevant licensing bodies. The policies require the facility to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's PREA related policies by contractors or volunteers. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.24 addresses this standard. Any resident found in violation of the facility's zero tolerance policy against sexual abuse may be subject to disciplinary action, following a disciplinary process. The resident may be transferred to another facility following an administrative or criminal finding of resident-on-resident sexual abuse. During the past 12 months there have been no incidents of resident-on-resident sexual abuse.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.05 states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed confirmed awareness of the policy and the requirements of the standard.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 13.05 and 13.06 provide that timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse will be provided. The nature and scope of the services are determined by medical and mental health practitioners according to their professional judgment.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.05 provides for ongoing medical and mental health care for sexual abuse victims. It also provides for medical and mental health evaluations and appropriate treatment in accordance with the standard. According to staff interviews and a review of documentation, health care is 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 13.25 addresses this standard. The policy will serve as the guide for staff in conducting incident reviews. The incident review team has been identified. Staff interviews indicated that the role of the incident review team is understood.

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:

Policy 13.30 and FDJJ 1919 require the collection of accurate, uniform data for every allegation of sexual assault. 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 13.30 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.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 13.30 and FDJJ 1919 address this standard and require that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed.

AUDITOR CERTIFICATION:

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

Shirley L. Turner

December 17, 2014

Auditor Signature Date