PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: August 21, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: July 11-12, 2017			
Facility Information			
Facility name: Orange Youth Academy/Orlando Intensive Youth Academy			
Facility physical address: 5150 39th Street, Orlando, FL 32839			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 407-835-0111			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Ryan Montgomery			
Number of staff assigned to the facility in the last 12 months: 68.5 (may have contact with residents)			
Designed facility capacity: 56			
Current population of facility: 53			
Facility security levels/inmate custody levels: Non-Secure/Moderate			
Age range of the population: 12-21			
Name of PREA Compliance Manager: Ryan Montgomery		**Title:** Facility Administrator	
Email address: ryan.montgomery@us.g4s.com		**Telephone number:** 407-835-0111, ext. 1001	
Agency Information			
Name of agency: G4S Youth Services, LLC			
Governing authority or parent agency: *(if applicable)*			
Physical address: 6302 Benjamin Road, Suite 400, Tampa, FL 33634			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 813-514-6275			
Agency Chief Executive Officer			
Name: Martin J. Favis		**Title:** Chief Executive Officer	
Email address: martin.favis@us.g4s.com		**Telephone number:** 813-514-6275	
Agency-Wide PREA Coordinator			
Name: Bobbi Pohlman		**Title:** PREA Coordinator	
Email address: bobbi.pohlman@us.g4s.com		**Telephone number:** 954-818-5131	

AUDIT FINDINGS

NARRATIVE

Orange Youth Academy/Orlando Intensive Youth Academy are dual programs located within the same facility in Orlando, Florida. The programs collectively provide substance abuse overlay services; mental health/special needs overlay services; intensive mental health services; social and life skills; education/vocational services; and recreation activities. Staffs provide evidenced-based treatment practices and incorporate the principles of restorative justice within the programs. Based on the individual needs of residents, they are afforded varying levels of individual, group and family therapy or counseling sessions and cognitive skills training sessions. The facility is managed through a contract between the Florida Department of Juvenile Justice (FDJJ) and G4S, LLC. The facility serves male juvenile offenders and the average length of stay is six to nine months.

The site visit to the facility conducted on July 11-12, 2017 was planned with the FDJJ statewide PREA Coordinator. Prior to the site visit, a conference call was held with the Facility Administrator who also serves as the PREA Compliance Manager, Assistant Facility Administrator, FDJJ PREA Coordinator, and a FDJJ program manager. Introductions were made during the conference call and the audit process and data gathering task were discussed. The posting of the signs announcing the site visit and the location of their placement were also discussed.

Pictures of the posted signs and the identity of the areas where they were placed were sent the this Auditor by email. The signs were located in areas accessible to the residents, staff and visitors. The posted signs announced the PREA audit, dates, Auditor contact information, and the purpose for any written contact that needed to be provided to the Auditor. The PREA Pre-Audit Questionnaire, policies and supporting documentation were uploaded to a flash drive and subsequently mailed to this Auditor. Upon completion of an assessment of the information provided, a written review was sent to the Facility Administrator/PREA Compliance Manager requesting clarification of information and additional documents. There was communication with the Facility Administrator and the Assistant Facility Administrator during the document review process, as needed.

On the first day of the site visit, a comprehensive tour of the facility was conducted by the Assistant Facility Administrator and included all areas of the facility and the outside grounds. During the tour, staff members that were encountered were introduced and their roles identified. Direct care staffs were observed supervising the residents. Groups of residents were observed to be involved in educational and recreation activities. The postings of the announcement of the site visit were observed in the locations previously identified in the pictures sent by email. Posters and other materials containing information for reporting allegations of sexual abuse were also posted in various areas of the facility, accessible to residents, staff and visitors.

A sample of residents, direct care staff, administrative staff, and treatment staff were interviewed. Contact was made by telephone with the victim advocacy agency who has entered into a written agreement with the facility regarding the provision of services. Ten residents were interviewed that covered the different housing areas and 10 direct care staff were interviewed that included all shifts. Eleven specialized interviews were conducted, including a contractor. The interviews with the staff and residents demonstrated their participation in PREA training.

Additional information and documents were provided during the site visit as needed and all staff and residents were cooperative during the interviews. The Facility Administrator and the Assistant Facility Administrator were kept abreast by this Auditor of the progress of the audit and the activities during the site visit. An exit conference was held on the second day at the conclusion of the site visit with the Facility Administrator, Assistant Facility Administrator and the Program Director. During the exit conference a summary of the audit findings was provided.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Orange Youth Academy/Orlando Intensive Youth Academy facility is located on grounds that contain seven buildings. The administrative building contains a reception area, offices and control room area. There are four single cell housing units that contain a day room area. The housing units also contain a bathroom area that provides a reasonable amount of privacy for residents to use the toilet, change clothes and take showers. The residents are assigned showers and the assignments are documented and are adjusted as new admissions occur. Laundry rooms are located in the housing units. There is a total of seven classrooms on the grounds.

In addition to the posters and signs regarding the PREA site audit and reporting allegations of abuse, there was also contact information regarding the request for advocacy services which were in the housing units and other areas of the facility. The posters for reporting allegations of abuse are in English and two other languages. The outside grounds contain a large basketball court and areas for various recreational activities. There is also a pavilion located on the front of the grounds. A maintenance building is located on the outside grounds.

A sign is posted at the entrance and inside of the housing units informing female staff members to announce their presence upon entering the housing units. Secured boxes are located in the housing units for residents to place completed sick call requests and grievances. There is no segregated housing within the facility. There are no investigators within the facility. Administrative investigations are conducted by the Florida Department of Juvenile Justice Office of Inspector General and allegations that are criminal in nature are investigated by local law enforcement.

The Health Service Administrator coordinates the medical services and also provides medical services along with two full-time Registered Nurses, one part-time Registered Nurse, and one Registered Nurse who provides coverage as needed. The Physician and Psychiatrist visit the facility weekly. The residents' receive eye examinations as indicated. Forensic medical examinations will be conducted at the local hospital. Mental health services are coordinated and provided by the Clinical Director. The mental health unit also consists of five Therapists and a Recreation Therapist. A Psychologist visits the facility weekly and a contract Sex Offender Therapist provides services to the facility as needed.

The Case Managers, under the direction of the Director of Case Management, collaborate with all units in the planning, facilitation and coordination of services to meet the comprehensive needs of the resident. Academic and career education services are provided by the Orange County School District. The education program offers English; Mathematics; Science; Social Studies; Reading; and one elective course. Direct care staff members are responsible for the general supervision of the residents and they assist in maintaining a safe and orderly environment. The comprehensive tour of the facility revealed that staff members provide direct and engaged supervision to the residents.

The residents are provided the opportunity to participate in daily recreation activities and outside when weather permits. During the comprehensive facility tour, as aforementioned, the residents were observed to be involved in recreation activities and they were being conducted on the outside grounds. A behavior management system exists which provides incentives for residents to adhere to the facility rules and accept responsibility for negative behavior.

SUMMARY OF AUDIT FINDINGS

The interviews with the residents and staff members revealed that they understood the facility's zero-tolerance regarding PREA and how to report allegations and/or incidents of sexual abuse or sexual harassment. The staff members encountered by this Auditor understood their responsibilities in prevention, reporting, and responses to allegations or incidents of sexual abuse or sexual harassment. The staff and residents were receptive to the site visit and cooperated with the interviews.

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; PREA Coordinator

☐ 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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility's PREA Policy, 10-25, is the zero-tolerance policy regarding all forms of sexual abuse and sexual harassment and it outlines the approach for preventing, detecting, and responding to such allegations. Policy 8-3, Abuse and Neglect Reporting provides support to the PREA Policy. The Florida Department of Juvenile Justice Policy 1919 (FDJJ 1919) serves as the comprehensive guide and policy in which the facility's PREA related policies are aligned. The PREA policies contain definitions of the prohibited behaviors and address sanctions to be used when the PREA related policies are violated.

The facility's and agency's PREA and related policies outline the strategies for addressing the components of the PREA Standards and include the following:
*prevention and responsive planning;
*training and education;
*risk screening;
*reporting;
*official response following a resident report;
*investigations;
*discipline;
*medical and mental care; and,
*data collection and review.

The Facility Administrator also serves in the capacity of the PREA Compliance Manager. He confirmed this role during the interview and a review of Policy 10-25 and the facility's organizational chart also verified the role. The Facility Administrator stated during the interview that he has the time and the authority required to fulfill his PREA related duties. Interviews conducted with random staff also confirmed their awareness of the role of the Facility Administrator as the PREA Compliance Manager. The Facility Administrator discussed in the interview the facility's efforts in achieving compliance and how it is a campus-wide effort and how information is shared regarding the PREA initiatives..

Standard 115.312 Contracting 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)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The standard is not applicable; the facility does not contract with other facilities for the confinement of its 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)

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Policy 10-25, the primary PREA policy for the facility, addresses this standard and provides guidelines regarding staffing, supervision and monitoring. The Policy outlines the considerations for staffing and provides guidance to staff in adhering to the staffing ratios of the contract of 1:8 during the waking hours and 1:8 during the sleeping hours.

The interview with the Facility Administrator and obsevations during the comprehensive facility tour revealed the adherence to the staffing ratios at that time. The staffing plan provides for the staffing ratios to be met and for a hold-over or "blue dot" system that ensures adherence to the staffing plan. During the interview with the Facility Administrator, there were discussions of the considerations for the development and maintenance of the staffing plan, including the composition of the resident population, identification of blind spots, and security and program needs.

Policy 10-25 also provides that at least once a year a review of the staffing plan occurs. The annual Staffing Plan Assessment was completed by the FDJJ statewide PREA Coordinator in conjunction with the Facility Administrator and includes but is not limted to a review of the staffing plan; monitoring system; resources available and committed to ensure adherence to the staffing plan; and the occurrence of unannounced rounds. The assessment also noted compliance with the contract requirements regarding the staffing ratios. The form summarizing the review is signed and dated by both the Facility Administrator and the FDJJ statewide PREA Coordinator.

Policy 10-25 provides for compliance to the staffing plan except during limited and exigent circumstances and that deviations from the staffing plan be documented. The facility reports that in the past 12 months there was no deviation from the staffing plan. The average daily number of residents during the past year is 56 and the average daily number of residents on which the current staffing plan was predicated is 56.

Unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment as provided for in policy 10-25. The unannounced rounds are documented with comments in the logbook. The Facility Administrator, Assistant Facility Administrator and the Program Director make unscheduled visits to the facility and ensures that staff are not alerting other staff regarding the unannounced visits. Policy supports the practice that staff does not alert other staff when the PREA rounds are occurring. According to the policy, staff who alert other staff regarding the unannounced rounds will be subject to disciplinary action unless there is a legitimate reason for the announcement.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

Policies 10-25 and 10-3 provide information to staff regarding searches and address the type of searches to be conducted and policy 8-14 supports this standard. Cross-gender strip and cross-gender visual body cavity searches are prohibited at the facility. Cross-gender pat-down searches are not permitted, except in exigent circumstances. The interviews with direct care staff members, residents and the Facility Administrator confirmed that cross-gender searches are not conducted. Although policy addresses exigent circumstances, direct care staff members intimated that for a cross-gender pat-down search to occur, there would be no other options available during an emergency situation.

The facility has begun the review and address with staff the searching of transgender and intersex residents. The review was addressed in a staff meeting and included a presentation on conducting searches in a professional and respectful manner, consistent with security needs. The FDJJ will work in conjunction with contract facilities regarding any standardized practices for the specific searches of transgender and intersex residents. The facility reports that no type of cross-gender searches have been conducted at the facility during this audit period.

Policies 8-14 and 10-25 prohibit staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status; this information was also verified through random staff interviews. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private.

Policy 10-25 and the facility practices ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. Random staff and resident interviews and observations of posted shower assignments confirmed the practices for residents being provided reasonable privacy by all staff. Policy 10-25 and posted signs inform female staff that they must announce their presence upon entering the housing unit and another sign is posted inside the unit which serves as a reminder to staff. According to staff and resident interviews, the female staff members announce their presence verbally when entering their living areas. During the comprehensive tour of the facility, this practice was utilized and observed.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 9-2 addresses obtaining support services for disabled residents. The facility staff has access to Registered Court Interpreters through the Florida State Courts System. Interpreting services may also be provided by facility staff, according to some interviews with Direct Care staff. The resident handbook may also be printed in a dominant language other than English.

The policy provides that residents with disabilities and who are limited English proficient be provided with the support services that would enable the identified residents to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment. The facility reports that during the past 12 months there has not been a need for interpreters.

The random staff interviews support that the facility does not rely on resident interpreters, resident readers or any type of resident assistants for the provision of PREA information for another resident as required by FDJJ 1919. The resident handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also posted on the living units and in various areas of the facility.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 3-16, FDJJ 1800 and FDJJ 1919 address hiring and promotion processes and decisions, including background checks. The collective Policies and interview with the Assistant Facility Administrator revealed information regarding the hiring process, completion of background checks, and the grounds for termination. The Policies are aligned with the requirements of the standard and provide that background checks occur and that child abuse registries are checked prior to employment and that background checks are conducted every five years. A review of a sample of personnel files with the Assistant Facility Administrator confirmed the practices.

A pre-hire form seeks information from applicants regarding previously related sexual misconduct allegations and convictions. The policies prohibit hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor who may have contact with residents who has engaged in previous sexual misconduct.

According to the Assistant Facility Administrator, the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee. Policies FDJJ 1800 and FDJJ 1919 and the interview with the Assistant Facility Administrator provide that staff has a continuing duty to report misconduct and provide that omissions of misconduct or providing false information will be grounds for termination.

Standard 115.318 Upgrades to facilities and technologies

☐ 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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The cameras are strategically placed to assist staff in the supervision and monitoring of residents. Portable units, used for education services, have been added near the education buildings since the last PREA audit in 2014. Additional cameras have been added to offset identified blind spots in various locations on the campus, including the portable education units.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 and random staff interviews revealed that the facility staff members are not responsible for conducting administrative or criminal investigations. Policies FDJJ 1919 and 10-25 and the interview with the Facility Administrator provide that the Florida Department of Juvenile Justice Office of the Inspector General is responsible for conducting administrative investigations; the Florida Department of Children and Families is responsible for conducting allegations of child abuse; and local law enforcement, is responsible for conducting investigations that are criminal in nature.

The Facility Administrator serves as the contact person for an investigation. The FDJJ provides each facility written information regarding PREA related investigations and comprehensive uniform evidence protocols developed after 2011 that is to be shared with their local law enforcement agency.

The facility has provided for victim services through a written Memorandum of Understanding (MOU) with the Victim Services Center of Central Florida. Victim assistance services include but are not limited to a forensic examination performed by a Sexual Assault Nurse Examiner; emotional support services; access to the Victim Services Center's hotline number; and the provision of posters and literature. The MOU also addresses conditions of confidentiality. There has been one allegation of sexual abuse during this audit period; it was investigated by local law enforcement and a forensic examination was not necessary.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 7-30, 10-25 and interviews with random staff and the Facility Administrator provide that allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by FDJJ Office of Inspector General trained investigators and sexual abuse allegations are referred for an investigation to the Orange County Sheriff's Office. The Department of Children and Families is also contacted regarding allegations of sexual abuse. The policies provide guidance to staff on reporting incidents or allegations of sexual abuse.

During the past 12 months there was no administrative investigations conducted. One allegation of resident-on-resident sexual abuse was referred to the Orange County Sheriff's Office for an investigation to be conducted. The allegation was also reported to the appropriate FDJJ unit. The policies provide that staff report all allegations of sexual harassment or sexual abuse and to document the reports. The staff members are aware of the policy requirements as verified through their interviews and a review of documentation. The FDJJ website provides the information and policy for reporting allegations of sexual abuse and reporting information is also posted in various areas of the facility, accessible to residents, staff and visitors.

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)

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Policies 5-1 and 5-2 address PREA related training for staff. The policies, training documentation and staff interviews confirmed that the staff training occurs. All staff interviewed were familiar with the PREA information regarding the primary components of preventing, detecting and responding to sexual abuse or sexual harassment. Basic PREA training is provided to staff, as indicated by policy and training documentation; refresher training is also provided for staff as needed. The direct care, medical and mental health staff interviewed reported receiving the PREA training as required. The facility provides program services for males and the training considers the needs of the population served. Policy 5.2 provides that PREA training is conducted every two years. Staff interviews and training documentation support that bi-annual training and refresher sessions are provided as needed.

The training provided to staff covers the requirements of the standard and include but is not limited to the following: facility and agency zero-tolerance and PREA related policies; staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment; resident's right to be free from sexual abuse and sexual harassment; the right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation; dynamics of sexual abuse and sexual harassment in juvenile facilities; residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment; and how to avoid inappropriate relationships with residents.

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)

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Policies 10-22 and FDJJ 1919 address this standard. Sample training documentation for volunteers and contractors were reviewed that documented the training. It includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment. The interviews with a contractor and volunteer confirmed their understanding of the facility's zero-tolerance of sexual abuse and sexual harassment.

The PREA training informs the contractors and volunteers of their role in reporting allegations of sexual abuse or sexual harassment. The contractors and volunteers are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation.

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)

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Policy 10-25 provide that all residents admitted receive PREA education which includes directions to residents about how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. The Youth Handbook also provides information to residents on how to report allegations of sexual harassment and sexual abuse. The Director of Case Management explained the process for ensuring that residents receive the information. Residents sign an acknowledgement statement confirming their receipt of the PREA education, which also includes a review of "Safety Tips" that are beneficial to the resident inside the facility and upon the resident's release.

The PREA related information is a part of the intake packet completed with each resident and residents sign an acknowledgement form. The intake packet includes a checklist used by the Case Manager to document the completion of each activity during the admission process. The checklist is maintained in the resident's file and among other admission's activities, it documents the provision of the intial PREA education session. Interviews with the Director of Case Management and residents and the review of documentation indicated that the PREA education sessions occur. The PREA related information is provided to staff in policies, training and staff meetings as observed and according to staff meeting minutes and staff interviews.

The facility has the capability of providing the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the PREA related information posted in the housing units and other areas. Facility and other G4S staff also provide support services to residents as needed and to enure access to services that will provide disabled residents the opportunity to participate in PREA education sessions.

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)

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Policies 10-25 and FDJJ 1919 and staff interviews document that facility staff members do not conduct investigations. Administrative investigations are conducted by the FDJJ Office of Inspector General and criminal investigations are conducted by the Orange County Sheriff's Office. The Department of Children and Families may also investigate allegations of sexual abuse. Policy FDJJ 1919 provide that Offie of Inspector General's investigators be trained on the related policies and procedures regarding the handling of sexual misconduct incidents and reports and in conducting allegations in the FDJJ settings. The Facility Administrator is the primary contact regarding sexual abuse investigations.

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)

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The FDJJ 1919 provide that medical and mental health staff members are required to receive the regular PREA training and the specialized training available online through the SkillPro training system provided by FDJJ. Documentation shows that mental health and medical staffs completed the general and specialized training provided through the SkillPro training system. Forensic medical examinations will not be 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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 9-1 and 9-2 provide that all youth admitted to the facility are properly screened. Staff and resident interviews and a review of documentation confirmed that residents are screened for risk of victimization and abusiveness. This vulnerability screening occurs within 24 hours of intake, whether the youth is transferred from another facility or is a new admission. The screening is conducted using the FDJJ objective instrument, Screening for Vulnerability to Victimization and Sexuality Aggressive Behavior (VSAB). This instrument is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; the youth's self-identification; current charges and offense history; and intellectual or developmental disabilities. Resident interviews, a review of a sample of VSABs, and the interview with a Therapist verified that the VSAB is administered.

According to the Therapist, the residents court packet is reviewed in preparation for interviewing the resident for the completion of the VSAB. Additional information for the VSAB is obtained through reviewing any mental health evaluations; talking to parents; and reviewing the MAYSI mental health screening tool which is administered prior to the VSAB. The Therapist further stated that the VSAB is administered through asking questions and probing as needed. A summary of the interviews conducted with residents implied that residents are asked safety questions in treatment team meetings. The information from the screening instruments is accessible to the Therapists and the Clinical Director and the files were observed to be maintained in a confidential and secure manner in a file cabinet in a locked office.

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)

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corrective actions taken by the facility.

Policies 8-14, 9-2, 10-18 and 10-25 address this standard. The Therapist confirmed that the information obtained through the administration of the screening instruments, including the VSAB, assist staff in determining room placement and shower assignments in efforts eliminate sexual abuse and address the needs of the residents. The information is also used to activate the Security Alert System regarding residents who may be a safety or security risk which involves special monitoring. Isolation is not used in this facility.

Interviews with direct care staff members indicated that protective measures would be taken immediately if it was determined that a resident was at risk for imminent sexual abuse. The interview responses regarding the protective measures that would be taken included but were not limited to one-on-one staff supervision; separate residents involved in the situation; document the situation and the action taken; and modify resident(s) shower schedule.

Policy 8-14 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 also prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. Facility and agency policies and staff interviews indicate that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis to ensure the resident's health and safety.

The staff members are aware of the practices that would be implemented when there are transgender or intersex residents within the population. The resident's concern for his own safety is currently taken into account through responses obtained from the administration of the VSAB and encounters with treatment staff as confirmed through resident interviews. Therefore, all residents concern for their safety would be considered.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 1-5; 8-3; and 10-25 address this standard and provide multiple internal ways a resident may report allegations of sexual abuse or sexual harassment; retaliation for reporting; and staff actions that led to an allegation. Residents also receive information on how they can privately report. Residents may report allegations of sexual abuse or sexual harassment by telephone and the FDJJ hotline and the Victim Services Center of Central Florida may be contacted. The resident and direct care staff interviews revealed that they are aware of the hotlines to report allegations of sexual harassment, sexual abuse or to request victim advocacy services.

Additional internal ways a resident may report allegations of sexual abuse or sexual harassment include completing an emergency grievance form; talk to any staff member; complete a Let's Talk form requesting to speak to a staff member in a particular service area of the facility; or complete a sick call form. Access to writing tools is provided for residents so that they are able to complete the forms.

Information about reporting allegtions of sexual abuse and sexual harassment is contained in the Youth Handbook and is posted in the housing areas and other areas of the facility. Resident and staff interviews summarized their awareness of the various methods a resident may report allegations. The facility reports that residents are not detained in the facility for civil immigration purposes.

There is an awareness by staff and residents regarding the acceptance of reports of allegations of sexual abuse or sexual harassment that are made verbally, written, anonymously, and by third-parties. All residents interviewed stated that they have contact with someone who does not work at the facility and could report abuse to that person if needed. The residents were aware that third-party reports could be made and that reports could be made anonymously.

Policies and staff interviews support that staff members are required to immediately document all verbal reports. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through written policies and procedures, training, staff meetings, and posted information as determined through a review of documentation, observations and staff interviews.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 8-4, FDJJ 1919 and the Youth Handbook provide that grievances regarding sexual abuse or sexual harassment may be completed and submitted at any time and may be placed in the locked grievance box. The resident is not required to handle an emergency grievance informally by attempting to resolve the situation with staff. During the past 12 months, there has not been a grievance submitted alleging sexual abuse or sexual harassment. When a grievance is received regarding sexual abuse or sexual harassment, it is to be immediately provided to the Facility Administrator, per policy. A response regarding the receipt of the grievance is provided to the resident within 48 hours. The policies and procedures for reporting allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policy.

The grievance system does not include a process for facility staff to investigate or resolve allegations of sexual abuse or sexual harassment. The content of the grievance is reported and an investigation may be conducted by the FDJJ Office of Inspector General; Florida Department of Children and Families; or local law enforcement when the allegation is criminal in nature. The purpose of the submission of a PREA related grievance provides residents and staff another avenue for ensuring the reporting of allegations and provides management staff with the opportunity to protect the resident. There is no time limit for a resident to submit an emergency grievance alleging sexual abuse or sexual harassment.

Policy 10-25 provides staff with the required information for reporting sexual abuse and sexual harassment of residents. The facility and agency policies provide that a resident may be disciplined when it has been determined that a report alleging sexual abuse has been made in bad faith. Residents understand that they will not be punished if a report is made in good faith, as determined through their interviews.

The residents and staff interviewed identified the grievance system as one of the methods that may be used to report allegations of sexual abuse or sexual harassment. The residents have access to grievance forms, writing materials, and locked grievance boxes for depositing the completed grievance form, as determined through observations during the comprehensive facility tour and interviews with residents and staff. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 and a Memorandum of Understanding (MOU) address this standard. The facility has a written agreement, MOU, with the Victim Services Center of Central Florida for the provision of forensic examinations by a Sexual Assault Nurse Examiner, access to 24/7 hotline services, and other advocacy services. Posters are located around the facility that identifies the Victim Services Center, in English and Spanish, and includes contact information. The MOU details the responsibilities of the Center as well as the responsibilities of facility staff. During the comprehensive tour of the facility, the posted information was observed.

The interview with the Facility Administrator; contact with the advocacy agency; review of the MOU and policies; and observations of posted information support that advocacy services have been arranged and will be provided when requested. Resident interviews and the interview with the Facility Administrator and observations during the comprehensive facility tour support that residents are provided confidential access to an attorney or other legal representative as requested and residents have reasonable access to their parents/legal guardian. Residents confirmed that they had someone on the outside to report allegations of sexual abuse if they needed to. Residents were aware of all of the visitation and telephone days.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 addresss third-party reporting and interviews revealed that residents are aware that third-party reporting of sexual abuse or sexual harassment can be done. All residents interviewed stated that they knew someone who did not work at the facility that they could report to regarding allegations of sexual abuse. Staff interviews revealed their knowledge of third-party reporting through the PREA training and that they can receive allegations from third-parties.

Information regarding reporting is provided through observed postings that are located in areas of the facility that are accessible to visitors, residents and staff members. The FDJJ website contains information regarding third-party reporting of allegations of sexual abuse. Interviews with direct care staff revealed how they can privately report and that they are aware of their obligation to receive and submit reported allegations made from a third-party. Staff members are also aware that they are to document all verbal reports. Interviews with residents confirmed their knowledge of what third-party reporting means.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 1-5; 8-3; 10-25; and FDJJ 1919 provide direction to staff and address reporting duties. Staff members are to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws. Documentation reveals that an allegation of resident-on-resident sexual abuse was reported and resulted in an investigation being conducted by the Orange County Sheriff's Office. The investigation by the Sheriff's Office was closed with a determination of unfounded regarding the allegation of sexual abuse. The case was also administratively closed by the Florida Department of Children and Families.

Staff members are instructed to immediately report all allegations to their immediate supervisor and the supervisors are to ensure the direct report to the Central Communications Center (CCC). Policy 10-25 prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. The CCC will make appropriate notification to senior DJJ management who will make notification to management overseeing the facility where the alleged abuse occurred. Policy 10-25 provides direction to staff regarding notifications.

During the interviews with direct care, mental health and medical staff, it was revealed that they understand that they are mandated reporters and must immediately report all allegations of sexual abuse and complete a written follow-up report. Direct care staff provided information that was aligned with the reporting requirements and that the expectation is that reports are documented immediately. The facility staff members are also required by policy to report allegations that were made anonymously or by a third-party. According to interviews with the clinical staff, the residents are informed at the initiation of services of the limitations of confidentiality and their duty to report.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 addresses this standard and require staff to protect the residents through immediately implementing protective measures. The direct care staff and Facility Administrator interviews revealed that protective measures would include: contacting the resident's Therapist; alerting supervisor; separating the the alleged victim from the alleged perpetrator; documenting the situation; and one-on-one staff supervision.

The Facility Administrator indicated that the expectation is that actions to protect a resident would be implemented immediately. The residents are provided safety tips for self-protection while in the facility; they are included in the Youth Handbook. Residents revealed that they are asked safety questions during treatment team meetings. During the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 address this standard. The Facility Administrator, upon receiving an allegation that a resident was sexually abused while confined at another facility, must notify the head of that facility where the alleged abuse occurred. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. The Facility Administrator must also notify the Central Communications Center to report the incident for an investigation.

The policies require the Facility Administrator to notify the facility head where the alleged incident occurred. The facility reports that during this audit period, there has not been a report about an incident of abuse occurring while the resident was confined in another facility. The Facility Administrator and the Assistant Facility Administrator expressed their awareness of the policy requirements.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 require that any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. The Policy directs the first responder to request that the alleged victim does not wash; brush their teeth; change clothes; wash or do anything that may destroy evidence. The direct care staff members are familiar with how to preserve physical evidence.

The policies instruct non-security staff who may act as a first responder to request that physical evidence be preserved and to contact direct care staff for assistance. The staff interviews revealed that they are aware of their duties related to responding to an incident or allegation of sexual abuse. During this audit period there was not an incident or allegation of sexual abuse that required the implementation of the first responder duties regarding preserving or maintaining evidence or the involvement of the Nurse.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a written institutional plan, Coordinated Response, which is an outline for the actions of the various identified staff such as the first responder, supervisors, medical, mental health, and management staffs. This coordinated response to an incident or allegation of sexual abuse is also aligned with Policies 10-25 and FDJJ 1919. The staff interviews revealed familiarity with the steps to take as outlined in the coordinated response plan.

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)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 provides protection to residents and staff from retaliation. The Facility Administrator/PREA Compliance Manager serves as the retaliation monitor. He understands the responsibility of observing various factors for determining whether or not retaliation would occur after a resident or staff reports allegations of sexual abuse or cooperates with an investigation. There has not been an incident of retaliation during the past 12 months. Retaliation monitoring may be conducted for 90 days, and longer where indicated, according to policy and the interview with the Facility Administrator.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. Segregated housing is not used in this facility.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 address this standard. Staff interviews and a review of documentation revealed that administrative investigations are conducted by the FDJJ Office of Inspector General and criminal investigations are conducted the Orange County Sheriff's Office. Sustained allegations as a result of a criminal investigation will be referred for prosecution. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. There was one alleged incident that was investigated by the Sheriff's Office and was closed with no criminal charges filed due to the findings of unfounded.

The policies direct facility staff to cooperate with investigations and the documentation reviewed indicates such. Policy FDJJ 1919 provides that an investigation is not terminated because the source recants the allegation as indicated by the investigation documents. The Office of Inspector General follows protocols in conducting administrative investigations in FDJJ settings and the Investigators receive training on the related agency policies.

Standard 115.372 Evidentiary standard 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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policy and practice of the FDJJ Office of Inspector General, responsible for administrative investigations, impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ 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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 10-25 provides that the PREA Compliance Manager notifies the alleged victim of the outcome of the investigation. Documentation review indicates that the information is provided to the resident and also in the case of the resident's release. During the past 12 months there was one allegation of sexual abuse made by a resident against another resident which was investigated by the Orange County Sheriff's Office. Written notification was provided to the resident who made the allegation.

The policies provide that following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been indicted, charged, or convicted. There has not been an allegation during this audit period regarding staff. The Facility Administrator remains abreast of investigations by serving as the primary contact person and is aware of this policy requirements.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 3-3 and 10-25 and the Employee Handbook provide for disciplinary sanctions, up to and including termination for those staff that violate the facility's sexual abuse and sexual harassment zero-tolerance policy. The facility reports that during this audit period, no staff member was disciplined for violating policy regarding sexual abuse or sexual harassment.

Disciplinary sanctions for violations of facility/agency policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff.

Policies provide that terminations or resignations by staff that would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. Interviews

with the the Facility Administrator and Assistant Facility Administrator indicated their awareness of the existing personnel policies and practices.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 and FDJJ 1919 were reviewed for this standard. According to the policies collectively and the interview with the Facility Administrator, contractors or volunteers who engage in sexual abuse will be prohibited from contact with residents and will be reported to law enforcement and to relevant licensing bodies.

The facility documents the training and takes measures to provide volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited and is a serious breach of conduct, as supported by the interview with a contractor. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 10-25 provide that sexual activity between residents is prohibited and court or administrative processes and sanctions occur after determination that the sexual activity was coerced. Residents would be disciplined for sexual contact with staff only when it has been determined that the staff member did not consent to the sexual contact. Isolation is not used in this facility.

Policy 1-5 provides for special treatment meetings within 24 hours of an incident report regarding rule violations, including resident-on-resident sexual abuse. The interview with the Facility Administrator revealed that the facility would collaborate with the Florida Department of Juvenile Justice regarding the subsequent plans for the resident that would hold him accountable for his actions. The interview also revealed that a resident may also be referred to law enforcement for charges and possible removal from the facility regarding resident-on-resident abuse.

Policy 10-25 states that anyone reporting in good faith shall be immune from any civil or criminal liability. During the past 12 months there have been no administrative findings or criminal findings of guilt regarding resident-on-resident sexual abuse. Policies 10-25 and the interview with the Clinical Director support that counseling or other interventions will be offered to address and correct the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after an incident. Any type interventions or treatment services provided will not be as a condition for the resident to access participation in education services, or other programs.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 9-1 and 10-25 were reviewed for this standard. Policy 9-1 requires for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse whether victim or perpetrator. Interviews with medical and mental health staff and a review of one of the sample case files with the Therapist confirmed the practice of residents being promptly seen by treatment staff. The records demonstrated that a resident who disclosed was seen promptly by the Therapist and all subsequent encounters were documented.

Summarily, the interviews with the residents and staff indicated that residents are generally seen by medical and mental health staff on the same day of admission as part of the intake process. Policy supports that information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and those staff, based on their need to know for security and management decisions.

Medical and mental health staff discussed their knowledge of informed consent, in accordance with policy. The facility has a consent form that would be used for residents 18 years and older prior to the healthcare personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 7-30 and 10.25 address this standard. Staff interviews and a review of documented practices revealed that emergency medical care and crisis intervention services will be provided by medical and mental health staff as required. Processes and services are in place for a victim to receive timely access to sexually transmitted infections prophylaxis, where medically appropriate.

A review of a sample of residents' files with a Therapist revealed that staff maintain secondary materials that document services. It is documented through policies and understood by the medical and mental health staff that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation.

According to the policies, coordinated response plan, and interviews with the Nurse and Clinical Director, residents have access to unimpeded access to emergency services and that medical and mental health services are determined according to the professional judgment of the practitioner. The interviews with the Nurse and the Clinical Director confirmed that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis. Staff interviews confirmed their awareness of the policies and the methods to implement for protecting residents.

It was determined from staff interviews and a review of policy and a sample of residents' files that medical and mental health staff maintain secondary materials regarding medical and mental health encounters and the treatment services provided. It was determined through the interviews with medical, mental health and direct care staff; interviews with residents; and review of the written response plan and other documentation that immediate medical treatment and crisis intervention services will be provided to an alleged victim of sexual abuse.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 7-30 and 10-25 were reviewed and address ongoing medical and mental health care for sexual abuse victims and abusers. Interviews with the Nurse and Clinical Director confirmed that on-going medical and mental health care will be provided for sexual abuse victims and abusers, as appropriate. Also, on-going services would include follow-up medical and mental health services and referrals as needed. The Nurse and Clinical Director confirmed that resident victims will be offered tests for sexually transmitted infections as medically appropriate.

Mental health and medical services are consistent with the community level of care as per the interviews and observations. The written agreement with the victim advocacy agency provides services to victims of sexual abuse. The policy provides and the Clinical Director is aware that a mental health practitioner will conduct a mental health evaluation within 60 days for a resident who discloses youth-on-youth abuse. All treatment services will be provided at no cost to the victim.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies 10-25 provides for an incident review to be conducted within 30 days of the completion of an investigation. The Policies outline the requirements of the standard for the areas to be assessed by the incident review team. The Policies also identify the positions that comprise the team.

The Facility Administrator is knowledgeable of the purpose of the incident review process. During this audit period, there was one allegation of sexual abuse. The investigation was completed by Orange County Sheriff's Office and the findings were that the allegations were unfounded. Therefore, an incident review was not required.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The FDJJ 1919 policy and a review of reports confirm that FDJJ collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for FDJJ facilities and contractors capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ).

The FDJJ maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with directives from FDJJ and FDJJ aggregates the sexual abuse data which culminates into an annual report. The agency provides DOJ with data as requested

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 provides guidance regarding this standard. The collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions as needed; and preparing an annual report based on the collected data. Annual reports are prepared by the FDJJ statewide PREA Coordinator that provides an assessment of the agency's progress in addressing sexual misconduct.

The annual report is approved as required. The report reflects that that the agency has compared the results of annual reports and uses them to continuously improve policies; procedures; practices; and training on a statewide basis. The annual report has been reviewed and the report is accessible to the public through the FDJJ website. There are no personal identifiers on the annual reports.

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 discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDJJ 1919 provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless statutes require otherwise. According to the policy, the aggregated sexual abuse data from all facilities will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified that there are no personal identifiers, as required.

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Shirley L. Turner August 21, 2017

Auditor Signature Date