PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Walton Youth Development Center				
Physical Address: 286 Gene Hurley Road, DeFuniak Springs, FL 32435				
Date report submitted: December 16, 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 24, 2014				
Facility Information				
Facility Mailing Address: 286 Gene Hurley Road, DeFuniak Springs, FL 32435				
Telephone Number: (850) 520-4642				
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 Walton Youth Development Center is located in DeFuniak Springs, Florida and is a 39-bed facility for male juvenile offenders in the age range of 13-18. The facility is operated by Universal Health Services, Inc. through a contract with the Florida Department of Juvenile Justice (DJJ) to provide treatment services for committed youth. The length of stay is three to nine months for moderate risk residents and nine to 12 months for residents identified as high risk. While in the facility residents participate in programming that include education and vocational services; social services; mental health services; recreation; and transition planning.

On-site medical care is provided by one Registered Nurse and one Licensed Practical Nurse. The contract physician visits the facility weekly. Mental health services are provided on-site by the Treatment Coordinator and two Therapists, with a contract psychiatrist visiting the facility at least every other week. The parent agency has a Director of Nursing and a Designated Mental Health Authority on staff, accessible to the facility medical and mental health personnel. Education services are provided by teachers through the Walton County School District. Vocational education is provided through the Home Builders Institute Pre-Apprenticeship Certificate Training program. Case Managers ensure coordinated efforts for individualized treatment plans. Youth Care Workers provide direct supervision of residents in daily activities and movement to and from activities and services. Ninety staff members have been employed at the facility during the past year.

The Walton Youth Development Center is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, the facility provides opportunities for community service projects that are constructed at the facility and delivered to various sites located in the community. Past projects, completed through vocational services, have included storage sheds for Habitat Humanity; construction of dog houses for the humane society; and construction of basketball racks for the local Boys and Girls Club.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program site consists of one main building where the front of it contains the entrance lobby and administrative offices. Beyond the front area are a large conference room, the medical clinic, and the entrance for the admission of new residents. The next part of the building includes the control room which separates two living units; kitchen and dining room; and the education area which consists of three classrooms, library, and computer lab. Located on the outside grounds are buildings that contain the vocational program, including administrative offices; work areas; and storage.

Bathrooms are located in each housing unit and they provide a reasonable amount of privacy for the residents. Each housing unit also has a laundry room. The outside grounds contain a recreation area in ample size to accommodate various recreation and other activities. The grounds also contain a chicken coop and several chickens in a fenced area. Under staff guidance, the residents take responsibility in caring for the chickens. The care of the chickens is therapeutic and provides vocational opportunities for the residents. The outside grounds also contain a garden.

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 audit process and data gathering. 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. During the review of the information on the flash drive, communication was maintained with the PREA Coordinator and 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 24, 2014. An entrance meeting was held with the Program Director, Assistant Program Director and the Treatment Coordinator. After the meeting a comprehensive tour of the facility was provided by the Assistant Program Director. During the tour, staff members were observed to be directly supervising and interacting with 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 upon request and in a timely 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 Assistant Program Director.

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)

☒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)

☒ Standard Not Applicable

Auditor Comments:

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

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.010 addresses this standard and provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse and that the ratios are per the current program contract. The facility reported no deviations from the current staffing plan in the past 12 months. The annual assessment of staffing and other areas has been conducted to determine whether adjustments are needed in accordance with the standard. An evaluation of staffing is 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 the appropriate staff. Interviews with staff confirmed the practice.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.100 prohibits cross gender pat-down searches; 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 and 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 confirmed these practices.

Policy 13.11 states that staff shall not search or physically examine a transgender or intersex resident to determine the resident's genital status. The related training and reviews have been provided. Policy 13.10 addresses opposite gender staff announcements. The facility has also implemented the practice that female staff~~s~~ announce their presence when entering an area where residents may be showering, changing clothes or performing bodily functions.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 1.150 addresses support services for residents with disabilities and residents who are limited English proficient so that they may benefit from and participate in PREA education. Resident education materials are available in dominant languages other than English. Policy 1.150 provides 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 will be used as needed.

.

Standard 115.317 Hiring and Promotion Decisions

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 1.130, FDJJ 1800 and FDJJ 1919 provide for background checks on all employees and contractors through a process that is used statewide. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted as required.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

A camera system serves as support to the direct supervision of residents by staff. The Program Director and the Assistant Program Director are able to view specific areas through desk top monitoring. There are a total of 32 cameras that are strategically placed and additional cameras have been requested. The preliminary work for the installation of the additional cameras has begun and replacements have been made to provide better video quality.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.18 addresses this standard. It 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)

☒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 13.27 and FDJJ 1919 provides that staff report all allegations of sexual abuse and sexual harassment and that the appropriate investigative entity be contacted when allegations of sexual abuse are made. There has not been an allegation from a resident at this facility during the past 12 months. The DJJ website contains information regarding the referral of allegations for investigations of sexual abuse. The facility posts related information which is accessible to the public.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 13.03 and FDJJ 1919 provides for the PREA training of all staff. The 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)

☒ 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)

☒ 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 13.00, 1.150 and FDJJ 1919 address this standard. A review of documentation and interviews with residents and staff confirm that residents receive information about the facility's zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment. According to 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. The 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 13.01 states that residents receive reassessments periodically. Interviews with residents and staff and a review of documentation confirmed that the screening is conducted.

Standard 115.342 Use of Screening Information

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 13.02 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Additionally, housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. According to the Policy, the facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. There have been no residents placed in isolation because of victimization.

Standard 115.351 Resident Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policies 13.22 and FDJJ 1919, 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 identifies specific staff he would like to talk to; write a note; talk to any staff member; and third parties may report allegations to staff. The grievance may be placed in the locked box located in the housing units. Interviews with staff and residents support the practices.

PREA related information is routinely 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 area of 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)

☒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 3.08 and 13.21 provide guidance about the grievance process and information is contained in the resident handbook. Residents may put a completed grievance form in the locked grievance box. Policy prohibits the use of an informal grievance process regarding allegations of sexual abuse and sexual harassment. The facility has enhanced existing policy and procedures for the filing of an emergency grievance alleging sexual abuse or 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)

☒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 facility has a MOU with Shelter House, Inc. that provides for advocacy services to the victim. A telephone conversation with the representative from the victim advocacy agency confirmed that victim services will be provided. The facility and the advocacy agency report 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 residents 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 facility.

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, FDJJ 1919 and Florida Statute 39.201, all staff members are mandated reporters. Staff members are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse, 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. Staff interviews support the policies.

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, immediate action is taken 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.

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 provided support for this process.

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:

Policies 13.20 and FDJJ 1919 guide the response to this standard. There has been no allegation by a resident regarding sexual abuse within the last 12 months. Staff training and a refresher have been provided.

Standard 115.365 Coordinated Response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

The PREA Institutional Plan documents the actions to be taken among staff in response to an incident of sexual abuse. The Plan includes first responders, leadership, medical and mental health staffs.

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 supports 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. The Policy instructs staff to report incidents of retaliation and states that, if the conduct is identified, the monitoring will be is ongoing.

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. 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. According to FDJJ 1919, an investigation is not terminated solely because the source of the investigation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

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)

☒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 provides 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)

☒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)

☒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 indicate that an incident regarding sexual abuse by a contractor or volunteer 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. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 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 formal 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)

☒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)

☒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 Policies 13.05 and 13.06, 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 will serve as the guide for staff in conducting incident reviews. The incident review team has been identified. Staff interviews indicated familiarity with the role of the incident review team.

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:

Policies 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:

Policies 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)

☒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 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

Auditor Signature

December 16, 2014

Date