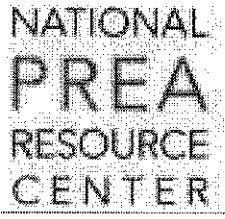
PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES



Name of Facility: Melbourne Center for Personal Growth			
Physical Address: 1000 Inspiration Lane			
Date report submitted: September 3, 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: August 4-5, 2014			
Facility Information			
Facility Mailing Address: Same as Physical Address			
Telephone Number: 321-752-3200			
The Facility is:	☐ Military	☐ County	☐ Federal
	☐ Private for profit	☐ Municipal	☐ State
	☒ Private not for profit		
Facility Type:	☐ Detention	☐ Correction	☒ Other: Residential
Name of PREA Compliance Manager: Norma Bolton		**Title:**	**Dir. of Case Management**
Email Address: spacecoast-DCM@amikids.org		**Telephone Number:**	**321-752-3200**
Agency Information			
Name of Agency: AMI Kids Space Coast, Inc.			
Governing Authority or Parent Agency: AMI Kids, Inc.			
Physical Address: 1000 Inspiration Lane, Melbourne, FL 32934			
Mailing Address: Same as Above			
Telephone Number: 321-752-3200			
Agency Chief Executive Officer			
Name: O. B. Stander		**Title:**	**CEO**
Email Address: OBS@amikids.org		**Telephone Number:**	**813-887-3300**
Agency Wide PREA Coordinator			
Name: Wendell Watson		**Title:**	**Regional Director**
Email Address: WLW@amikids.org		**Telephone Number:**	**321-863-1492**

AUDIT FINDINGS

NARRATIVE:

The Melbourne Center for Personal Growth is located in Melbourne, Florida and is operated by AMI Kids Space Coast through a contract with the Florida Department of Juvenile Justice (DJJ). It is a moderate risk non-secure residential treatment facility that serves male juvenile offenders between the ages of 14 and 18. The length of stay is six to nine months. The facility capacity is 28. Fifty-three residents have been admitted to the facility in the past 12 months.

Forty-seven staff members have been employed at the facility during the past year. Medical services are provided on-site by a full-time Registered Nurse and there is a part-time nurse position. The contract physician visits the facility at least weekly. Mental health services are provided by on-site staff through a contract with Circles of Care. The mental health staff includes the Director of Treatment, three full-time therapists and one part-time therapist, and a psychiatrist who visits the facility at least once every two weeks. Each resident receives daily group treatment services and individual, family and trauma-focused therapy as prescribed by his therapist. Education services are provided at the facility by certified teachers through the Brevard County School District. The education services include general education courses, GED preparation, vocational education, and credit recovery. The education courses focus on English, Math, Science, Social Studies and one elective course. The elective course is generally used to provide additional reading assistance, if needed or for vocational training.

The facility provides structured recreation activities and community service projects. Through experiential education the facility provides opportunities for residents to participate in life experiences that they may not have been exposed to if it was not for this program. The facility uses a blend of evidence-based substance abuse treatment techniques, behavior modification and education as a part of its treatment approach.

DESCRIPTION OF FACILITY CHARACTERISTICS:

There are four buildings that encompass the Melbourne Center for Personal Growth. The main building consists of administrative offices and other space; medical office and examination room; conference room; and a section of the building for mental health staff, including offices and cubicles. Another building contains the classrooms, kitchen and dining room. There is a building with two wings that serves as the housing unit. Each of the housing areas contains a large dormitory style room containing bunk beds and a bathroom. Residents are now provided a reasonable amount of privacy during showers within their housing unit due to the addition of shower curtains since the on-site PREA audit. There is a large multi-purpose room that separates the two housing wings and a laundry room and a bathroom are located in the multi-purpose room area. There is a smaller building that is used by the residents as a work-out room and it includes weight equipment.

A picturesque gazebo sits in the middle of the campus behind the administrative building, in front of the housing areas and the school. The grounds adjacent to the facility provide ample space for various outside large muscle exercises, recreation and other activities.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. Telephone conversations were held with the Executive Director and the PREA Compliance Manager to review the PREA audit processes. The facility policies and supporting documentation were uploaded to a flash drive, which was received by the Auditor prior to the on-site audit. After reviewing the information, notes were sent to the Executive Director and the Compliance Manager to seek clarity of information and to note the additional documents needed. In response to the issues noted, additional information was provided and discussed during the site visit.

The on-site audit was conducted August 4-5, 2014. An entrance meeting was held with the Executive Director, Director of Operations and the PREA Compliance Manager who also serves as the Director of Case Management. After the meeting a comprehensive tour of the facility was conducted by two residents accompanied by the Executive Director, Director of Operations and the PREA Compliance Manager. During the tour, staff members were observed to be actively engaged with the residents. Random staff, specialized staff and residents were interviewed during the on-site audit process. The interviews of both staff and residents confirmed that they had received PREA training. The staff members interviewed were knowledgeable of the related policies and their duties and responsibilities as they relate to PREA compliance. The residents interviewed demonstrated their knowledge of what PREA means and how to report sexual assault and sexual harassment. At the conclusion of the audit, a summary of the findings were provided in a close-out meeting with the Director of Operations and the PREA Compliance Manager.

Number of Standards Exceeded: 0

Number of Standards Met: 36

Number of Standards Not Met: 0

Number of Standards Not Applicable: 5

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 Melbourne Center for Personal Growth has a compilation of PREA policies and procedures that are inclusive of the overarching Florida Department of Juvenile Justice PREA Policy, 1919 (FDJJ 1919). The policies and procedures provide guidelines for implementing the agency's approach to complying with the requirements of the PREA standards including zero tolerance toward all forms of sexual abuse and sexual harassment. Policy 6.11 contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. The Director of Case Management has been identified as the PREA Compliance Manager.

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 agencies 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 6.13 requires an annual assessment of the staffing plan. A review of documents showed a completed internal assessment of staffing. The staffing plan is predicated on a daily census of 28. The Policy states that when the required ratios are not met due to limited and discrete exigent circumstances, the deviation from the plan will be documented in the facility logbook. The Policy and practice require the Executive Director, Director of Operations, Director of Case Management and the Director of Education to conduct unannounced rounds to deter sexual abuse.

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 6.15 prohibits staff from searching a transgender or intersex resident to determine the resident's genital status. The Policy also prohibits cross-gender strip and visual body cavity searches and cross-gender pat-down searches. The viewing of residents by opposite gender staff while they are showering, changing clothes, and performing bodily functions is not permitted, unless there are exigent circumstances. Shower curtains have been installed at the individual shower stalls since the on-site audit, providing the resident with a reasonable amount of privacy.

There have been no cross-gender pat-down, strip or body cavity searches of residents during this audit period. All staff interviewed said that the facility policy and practice are that cross-gender searches are prohibited. Interviews with residents confirm the practice. Staff and resident interviews also confirmed that staff members of the opposite gender announce themselves when entering the housing areas or other areas where residents may be 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:

According to Policy 6.16, the facility will not rely on resident interpreters, resident readers or any kind of resident assistance except when a delay in obtaining interpreter services would jeopardize a resident's safety or an investigation and such cases must be documented. The facility has the capability to provide residents with support services by contracting with individuals from a list of certified providers in the Brevard, Orange and Osceola County areas.

Standard 115.317 Hiring and Promotion Decisions

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy provides for background checks on all employees and a process that is aligned with the standard and DJJ policies. Applicants and employees are asked about or informed of previous misconduct. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

☐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 use any electronic monitoring technology.

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:

According to Policy 6.21, victim advocacy services will be provided. The facility has MOUs with Sexual Assault Victim Services and the agency, Circle of Care which also provides the facility with mental health services. When requested, a qualified staff member from either agency will provide support services including accompanying the victim through the forensic medical examination process and investigatory interviews; crisis intervention; information and referrals; and emotional support. The provision of services to be provided was confirmed

through interviews. Forensic medical examinations will be provided at a local hospital, Wuesthoff Medical Center, by qualified medical practitioners. There has not been a need for a forensic medical examination during this audit period.

According to FDJJ 1919, the facility is not responsible for conducting administrative or criminal investigations. The DJJ Office of the Inspector General (OIG) is responsible for conducting administrative investigations; the Florida Department of Children and Families (DCF) is responsible for conducting allegations of child abuse; and the local law enforcement agency, Brevard County Sheriff's Office, is responsible for conducting criminal investigations.

Standard 115. 322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.22 and FDJJ 1919 identify the agencies that will conduct the criminal and administrative investigations. Policy instructs the facility staff to cooperate with the OIG investigations. Facility policy ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. During the past 12 months, there were no allegations of sexual abuse or sexual harassment that required an administrative or criminal investigation.

The policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is available to the public on the DJJ website. Information regarding reporting sexual abuse is included in the letter that is a part of the intake package sent to the parent/legal guardian from the facility.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.31 provides for the PREA training. The staff training is comprehensive and covers the key areas referenced in the standard. A review of the training documentation and interviews with staff confirms that the training is provided.

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 6.32 contains information regarding the training of volunteers and contractors who have contact with residents. According to the Policy, the training is based on the services provided. Receipt of the training is documented.

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:

Policy 6.33 requires that residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. During the intake process residents are provided an education session regarding PREA. A signed acknowledgement statement by the resident of his having received the training is maintained in the case management file. Residents transferring from another facility will also receive the PREA education during the intake process. The residents are provided refresher training periodically during their stay at the facility.

PREA education will be provided through accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled. Support services may be provided through local certified providers.

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 6.35 addresses this standard. The facility has provided the medical and mental health staff members with the on-line 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:

Policy 6.41 addresses this standard. The Screening for Vulnerability to Victimization and Sexually Aggressive Behavior instrument is completed on each resident. Staff and resident interviews and a review of documentation confirm that screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being 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 6.42 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The

facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. If the situation occurs, isolating any resident will be done only as a last resort when less restrictive measures are inadequate to keep the resident or others safe, according to the Policy. The facility does not have an isolation room or segregated housing. There have been no residents isolated in the last 12 months because he or she was at risk of sexual 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:

There are internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation(s) that led to abuse. A resident may talk to any staff member; put the information in writing and give it to any staff member; the DJJ hotline numbers are available and accessible; and third parties may report allegations to the facility or the hotline numbers. A dedicated phone is provided in the multi-purpose day room in the housing unit, accessible to all residents, to call the rape crisis center hotline.

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)

☒Standard Not Applicable

Auditor Comments:

This standard is not applicable. According to Policy 6.52 and staff interviews, the facility considers resident grievances regarding sexual abuse to be an allegation of sexual abuse and when such a complaint is received, reporting and investigation policies are initiated. The Policy states that allegation of sexual harassment grievances will be addressed through the facility's grievance system. There have been no complaints 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 6.53 supports the residents having access to outside victim advocacy services. A MOU has been obtained with the local rape crisis center through Sexual Assault Victim Services. The information about the services is explained to the resident during the intake process. A dedicated phone is provided in the housing area for the resident to call the rape crisis center hotline number, if needed.

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 6.54 provides information regarding third-party reporting of sexual abuse. Pamphlets regarding reporting sexual abuse and sexual harassment are available at the check-in counter in the administration area, accessible to the public. Posters containing reporting information are displayed in various areas of the facility, including areas that are accessible to the public.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.61 and the Florida Administrative Code Rule 63F-11 address this standard. All staff members are required to report any allegation of sexual misconduct or youth-on-youth sexual activity to the Central Communications Center (CCC). The Policy states that staff members are prohibited from revealing any related information to anyone other than is necessary. The Policy requires that staff members are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment; retaliation against residents or staff who report any incidents; any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

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 6.62 addresses this standard and provides steps to take when staff learns that a resident is subject to substantial risk of imminent sexual abuse. The Policy requires staff to takes immediate action to protect the resident. There have been no incidents in the last 12 months where 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:

Policy 6.63 requires that upon receiving an allegation that a resident was sexually abused while confined in another facility, the Executive Director or his designee will notify the head of that facility as soon as possible but no later than 72 hours and the appropriate investigative agency. In the past 12 months, there have not been any allegations of sexual abuse occurring to a resident while he was in another facility.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 6.64 outlines the first responder duties and responses. There have been no allegations that a resident was sexually abused within the last 12 months. Staff interviews confirmed that they are knowledgeable of their duties as a first responder.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The coordinated response is incorporated in the facility's Policy 6.65 and is aligned with FDJJ 1919. Interviews with staff support that an institutional plan has been developed and that they are familiar with their roles. The plan coordinates the actions to be taken among facility first responders and other staff in response to an incident of sexual abuse.

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

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒Standard Not Applicable

Auditor Comments:

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

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policy 6.67, the Shift Supervisors will be directly responsible for ensuring all residents and staff members who report sexual abuse or sexual harassment are protected from retaliation. The Director of Operations is responsible for monitoring for possible retaliation. Staff members engaging in retaliation will receive disciplinary action including and up to termination. Residents engaging in retaliation will receive a disciplinary work detail and loss

of privileges. If the retaliation conduct is identified, the monitoring would be conducted for no less than 90 days and longer if indicated. The form, PREA Retaliation Monitoring Report, will be used to document the monitoring activities. There have been no incidents or allegations of sexual abuse within the last 12 months and not a need for retaliation monitoring.

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)

☒ Standard Not Applicable

Auditor Comments:

This standard is not applicable. Segregated housing or isolation is not permitted.

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 6.71 and FDJJ 1919 address this standard. Administrative investigations are conducted by the DJJ Office of Inspector General and criminal investigations are conducted by the local law enforcement agency. The Florida Department of Children and Families are also called when there is an allegation of sexual abuse. Both Policies direct facility staff to cooperate with the investigations.

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:

The OIG, responsible for administrative investigations, imposes 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 Comments:

Policy 6.73 and FDJJ 1919 address this standard. The facility's policy provides for staff to notify the resident following an investigation. The form, Resident PREA Allegation Status Notification, will be used to document the notification and the resident's signature is required acknowledging receipt of the information. There has not been an allegation of sexual abuse in the past 12 months.

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 6.76 provides for disciplinary sanctions for staff to be up to and including dismissal for violation of the facility's zero-tolerance against sexual abuse and sexual harassment. In the past 12 months, no staff has been terminated or has resigned for violating the facility PREA 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 6.77 addresses the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. They will be reported to local law enforcement and to relevant licensing bodies. The contractor or volunteer is prohibited from having contact with residents. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative agency 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 6.78 addresses this standard. Any resident found in violation of the facility's zero tolerance policy regarding sexual abuse, sexual assault, sexual misconduct or sexual harassment against another resident will receive disciplinary sanctions after a formal disciplinary process. The facility does not use isolation as a disciplinary sanction. The Policy also states that the facility may discipline a resident for sexual contact with staff only upon finding that the staff did not consent to such contact. The resident will be referred to Circle of Care for therapy, counseling or other interventions to address the underlying reasons or motivations for the abuse. There has been no incident of resident-on-resident sexual abuse in the past 12 months.

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 6.81 provides that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse during an intake screening 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:

Policy 6.82 requires that treatment services to every victim will be provided at no cost to the victim. It also states that services will be provided regardless of whether or not the victim cooperates with any investigation due to the incident. Staff interviews confirmed that the nature and scope of the medical and mental health 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 6.83 addresses ongoing medical and mental health care for sexual abuse victims and abusers. It also provides for the appropriate tests to be provided. The facility will attempt to obtain a mental health evaluation within 60 days of learning of resident-on-resident abusers and offer treatment deemed appropriate by a mental health practitioner. Interviews confirmed awareness of the Policy and how it would be implemented.

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 6.86 states that the sexual abuse incident review team will include upper-level management and allow for input from line supervisors, investigators, and medical and mental health staff. The meetings will be documented using the Sexual Abuse Incident Review Report form. There have not been any criminal investigations conducted at the facility in the last 12 months; however, the policies will serve as the guide for staff in conducting sexual abuse incident reviews.

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:

FDJJ 1919 and interviews with staff confirmed that DJJ collects incident-based, uniform and aggregated data regarding allegations of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Policy requires the collection of accurate, uniform data for every allegation of sexual assault. 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 Comments:

FDJJ 1919 addresses this standard. The statewide PREA Coordinator will review the collected and aggregated data to assess and improve the effectiveness of the PREA related efforts and initiatives. The Policy also states that an annual report will be prepared. A review of documentation confirms this practice.

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:

According to FDJJ 1919, it is required that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed. A review of documentation confirmed the practice.

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

September 3, 2014

Date