PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 02-02-2017

Auditor Information			
Auditor name: David "Will" Weir			
Address: POB 1473; Raton New Mexico 87740			
Email: Will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: June 14 and 15, 2016			
Facility Information			
Facility name: N. A. Chaderjian Youth Correctional Facility			
Facility physical address: 7650 South Newcastle Rd; Stockton CA 95213			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 209-296-7581			
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: Teresa Perez			
Number of staff assigned to the facility in the last 12 months: 280			
Designed facility capacity: 600			
Current population of facility: 225			
Facility security levels/inmate custody levels: Low/High/ Exempt			
Age range of the population: 14-24			
Name of PREA Compliance Manager: Steve Islas		**Title:** Lieutenant	
Email address: steve.islas@cdcr.ca.gov		**Telephone number:** 209-244-6407	
Agency Information			
Name of agency: Division Of Juvenile Justice (DJJ)			
Governing authority or parent agency: *(if applicable)* California Department of Corrections and Rehabilitaion			
Physical address: 8260 Longleaf Drive, Suite 201; Elk Grove, California 95758			
Mailing address: *(if different from above)* PO Box 588501; Elk Grove CA 95758-8501			
Telephone number: (916) 683-7460			
Agency Chief Executive Officer			
Name: Anthony Lucero		**Title:** Director	
Email address: Anthony.Lucero@cdcr.ca.gov		**Telephone number:** 916-683-7450	
Agency-Wide PREA Coordinator			
Name: Paul Woodward		**Title:** PREA Juvenile Coordinator / Program Mgr.	
Email address: paul.woodward@cdcr.ca.gov		**Telephone number:** 916-683-7760	

AUDITFINDINGS

NARRATIVE

PREAmerica LLC was retained on 03-21-2016 to perform The N. A. Chaderjian Youth Correctional Facility PREA Audit by California Contract Manager Richard Zeunges. California PREA Juvenile Coordinator and Program Manager Dr. Paul Woodward scheduled the onsite audit. Notices of the on-site audit went up by 04-22-2016 and the Pre-Audit Questionnaire with related documentation was received June 3, 2016. The on-site audit was conducted as planned on June 14 and 15. The audit team was given a tour then random interviews were conducted with residents and staff. The audit team interviewed 18 staff, including specialized and administrative staff. The audit team made sure to interview staff from each shift and each housing unit. 18 randomly selected residents were interviewed. These included residents from each housing unit. The audit team was impressed by the professionalism of the staff, and the positive morale of the residents who generally indicated they felt safe at NACYCF. Interviews of residents and line staff generally indicated an emerging compliance with the PREA standards they were interviewed about. The audit team conducted an exit conference at the conclusion of the onsite audit. The conference was well attended, with the conference room being filled with the leadership from both NACYCF and OHCYCF and representatives from numerous facility departments. Two headquarters staff joined the conference by speaker phone. They were Karen Heintschel, Program Administrator, and Teresa Perez, Associate Director of Programs. Ms. Heintschel has since become the agency's PREA Coordinator and Ms. Perez is now the Superintendent of NACYCF and OHCYCF. Perhaps the most impressive trait of the culture of the staff (and administration) of this institution is the commitment to learn from history and to duplicate safeguards that assure safety and comprehensive responses to incidents. Documentation regarding allegations and incidents are reviewed up the chain of command in each department (assuring an automatic referral to Mental Health) as well as in frequent meetings and conferences (face to face and electronically) held by administrators. One example is the exit interviews held with discharging residents, and the regard placed on the information gained in these interviews. Superintendent Erin Brock refers to their diverse accountability and information gathering systems as "checks and balances" because they may involve outside entities such as the Office of Inspector General, Child Protective Services, and Ombudsmen. The facility is staffed with a variety of professionals who have a wide array of expertise and credentials, helping to assure effective directed responses and appropriate division of labor. Examples include the Conflict Resolution Team, and other teams that assist with disability services, medical, grievances, and training improvement. Superintendent Brock states there are at least 3 systems of accountability in place that cover everything that happens. Follow-up is the rule. She states there are codes of conduct, but a code of silence is prohibited. The audit team also reviewed the areas for improvement referred to below.

On July 19 a PREA Audit Interim Report was issued to the agency by the auditor.

On July 18 the facility, agency, and audit team participated in a conference call developing details that were written up in a 180 Day Corrective Action Plan (CAP) and distributed for feedback, revision, and implementation. There were 19 standards addressed on the plan: §115.315 because additional privacy was needed due to cross gender supervision of shower areas and because policy still allows cross gender pat down searches absent exigent circumstances; §115.322 because auditor had not received adequate documentation to show that all allegations had been referred for proper investigation; §115.341 & §115.342 because the screening/rescreening tools for risk of abusiveness and victimization had to be improved, reissued, and implemented into practice to be utilized in decisions regarding housing, bed, program, education, and work assignments; §115.353 because the auditor needed additional proof that staff and residents are being made aware of outside advocacy services and that they are being offered to victims; §115.361 because audit team had not been able to verify that agency reporting duties were in practice and that policy updates had been fully approved and implemented; §115.363 because the auditor had not been able to verify the way an allegation received from another facility was handled; §115.364 because verification was needed that complete first responder duties had been distributed and was available to staff; §115.367 because verification was needed that the facility/agency was checking for retaliation; §115.371, §115.372, §115.373, §115.376, §115.378, §115.382, §115.383, & §115.386 because verification was needed that thorough and objective investigations were being completed, along with appropriate treatment, intervention, protection, and followup work; and §115.388 & §115.389 because annual reporting had not yet been completed. More details regarding these standards are included later in this report under the respectively numbered sections. Although some progress has been made toward these goals, the facility has not demonstrated full compliance with these 19 standards. Revised policies were developed and submitted for approval and the auditor has been provided updates regarding their progress through the agency's approval system. PREA Standards do not allow more than 180 days for corrective actions to be implemented and verified during an audit, so it is anticipated that these changes will be in place and verified in the next PREA Audit.

It should be noted that the audit team audited 4 (NACYCF, OHCYCF, VYCF, and PGYCC) DJJ facilities in the same time period, under the coordination of the PREA Coordinator, Dr. Paul Woodward, who was from what is referred to as the agency "Headquarters". The facilities rely heavily on direction from their agency head offices. Rather than implementing the proposed policies in each of their own facilities to quickly pass an audit, the leadership of these facilities continue their unified agency-wide approach, honoring their centralized system. The agency plans to implement the remaining details of PREA compliance in the way it normally implements systemic change to assure quality, effectiveness and performance of policies and procedures that stand the test of time. The audit team observed nothing, and was told nothing in the interviews that were conducted, that indicated any lack of intention or lack of commitment to fully protect and appropriately care for the residents. Rather, the audit team was impressed by the delivery of a number of evidence-based programs and services by credentialed and experienced professionals who have earned the respect of residents who say they have hope for their futures and believe they are getting help they need.

DESCRIPTION OF FACILITY CHARACTERISTICS

The N. A. Chaderjian Youth Correctional Facility located in Stockton, in San Joaquin County, and houses male youths 18 to 25 years of age in living units comprised of individual rooms.

N. A. Chaderjian High School provides instruction in basic skills, high school courses, special education, and vocational programs. Community college coursework is available through correspondence programs. The Free Venture Program provides work experience in an industrial setting.

This facility has two residential mental health units (an Intensive Behavior Treatment Program [IBTP] and a Mental Health Residential Unit [MHRU] program), a residential sex offender treatment program, and offers substance abuse treatment to all youth who need it.

It is located on a campus with an adminstrative complex and a shared medical facility and 6 other housing buildings. There are security cameras throughout the premises.

SUMMARY OF AUDIT FINDINGS

The N. A. Chaderjian Youth Correctional Facility received its onsite PREA Audit on June 14 and 15, 2016. The facility was able to demonstrate compliance with 21 PREA Standards and had 19 additional standards to demonstrate compliance with during the 180 Day Corrective Action Plan (CAP). Facility administrators, the audit team, and the DJJ PREA Coordinator actively collaborated in the development of the CAP, but NACYCF did not demonstrate full compliance with any additional standards during the corrective action period.

Number of standards exceeded: 0

Number of standards met: 21

Number of standards not met: 19

Number of standards not applicable: 1

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 has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. According to interviews with residents and staff, there is a commitment to the zero tolerance policy and the safety of the residents. The agency employs and designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in the facility. There is also a PREA Compliance Manager, Steve Islas, on site.

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.

NA. The facility reports no contracts with other entities 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)

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.

NACYCF develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. In calculating adequate staffing levels and determining the need for video monitoring, it takes into consideration: generally accepted juvenile detention and residential practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); the composition of the resident population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable State or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. At least once every year the agency, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to: the staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. NACYCF documents unannounced rounds on all shifts with a prohibition of staff alerting other staff of the conduct of the rounds. Auditor reviewed staffing plans, along with research and rationale upon which they are based, which were provided to the audit team.

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.

Agency policy prohibits cross-gender strip searches or cross-gender visual body cavity searches except in exigent circumstances which must be justified and documented, or when performed by medical practitioners. However, the agency policy does not prohibit cross-gender pat-down searches except in exigent circumstances. Policies enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. However, during the onsite audit, cross gender viewing could occur in some places when youth were in showers which were in clear sight of the control center without privacy barriers, or in places where cross gender staff regularly patrol. Privacy screens were, by agreement, to be installed during the Corrective Action Period but the auditor received no verification of this. It should be noted that there are showers which offer enough privacy to meet this standard. Policies and procedures that require staff of the opposite gender to announce their presence when entering a resident housing unit appears to be followed, according to interviews. Interviews and review of policy indicates the facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Additional training will be in order regarding cross-gender pat-down searches once the pending policy on this is approved. Other training regarding appropriate searches is already in place. It should be noted that interviews indicate cross gender pat searches are rare and progress toward compliance with this standard appears to be well underway.

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.

The agency has established procedures to provide disabled residents, and residents with limited English proficiency, equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under ß 115.364, or the investigation of the resident's allegations. In the past 12 months, according to documentation provided to the audit team, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under ß 115.364, or the investigation of the resident's allegations. Staff and residents indicate staff sometimes go the extra mile to assist anyone to understand what they need to understand in order to be safe and exercise their rights. Staff interviews and policy reviews indicate these efforts have been required and practiced in the agency culture for a number of years.

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.

The agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. The Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Agency policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks, consults any child abuse registry maintained by the State or locality in which the employee would work; and consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the past 12 months all staff and contract persons who may have contact with residents have had criminal background record checks. The Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Compliance with this standard was verified through a close reading of policy and other documentation provided, as well as a review of random personnel files pulled at the auditor's request, and through interviews with administrators, including HR Director.

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 agency or facility has has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. The facility conducts ongoing efforts to upgrade their video monitoring system, electronic surveillance system, and other monitoring technology. Documentation provided, as well as interviews with administrators, indicate PREA is considered, and will be considered when updates occur in the future.

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.

The agency/facility is responsible for conducting administrative investigations,while the California Highway Patrol are responsible for criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Child Protective Services, and local law enforcement and district attorneys have the criminal investigative responsibilities, as does the California Department of Corrections and Rehabilitation for some circumstances. When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth and based on the most recent edition of the DOJ's Office on Violence Against Women publication, A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, or similarly comprehensive and authoritative protocols developed after 2011. As verified by policy and interviews, residents who experience sexual abuse have access to off site forensic medical examinations. These examinations are offered without financial cost to the victim and are conducted by Sexual Assault Forensic Examiners (SAFEs) or (SANEs) at San Joaquin General Hospital. When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. These polices and procedures were verified in line staff interviews as well, when staff remember these available services when recanting their first responder duties. The agency does not yet have a formal agreement with the hospital, but has an active and respected verbal agreement. No forensic medical exams have been performed during the past 12 months because there were no allegations indicating an exam. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means and these efforts are required to be documented.

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.

NACYCF and DJJ written policy ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, according to interviews and documentation provided. However, the auditor was not able to verify this since, either the investigation was not completed, or the entire investigations was not provided to the auditor for review. In the past 12 months at least one allegation of sexual abuse or sexual harassment was received. The agency has a policy, that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency requires itself to document all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. This standard was included, by agreement, in the Corrective Action Plan (CAP), but adequate verification was not received by the audit team.

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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As verified by interviews with staff, the facility and the agency trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' right to be free from sexual abuse and sexual harassment; the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, and including relevant laws regarding the applicable age of consent. Such training is tailored to the gender, as well as any unique needs and attributes of residents. In the past 12 months 66 staff employed by the facility, who may have contact with residents, were trained in PREA requirements. Between trainings, the agency provides employees with refresher information about current policies regarding sexual abuse and sexual harassment in handouts and staff meetings. The agency documents that employees understand the training they have received through employee signature. This verification was provided to the auditor.

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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Volunteers and contractors who will have contact with residents have been trained on their responsibilities under the agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. According to interviews, 39 volunteers are utilized at this time. The level and type of training provided to volunteers and contractors is based on the services they will provide and level

of contact they will have with residents. All volunteers and contractors who will have contact with residents will have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency will maintain documentation confirming that volunteers/contractors understand the training they have received.

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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Facility residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. All residents admitted during the past 12 months have received this information in an age appropriate fashion, according to interviews and information provided. Many have received the information at previous placements as well. The agency maintains documentation of resident participation in PREA education sessions and this was provided to the auditor. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats, as verified in interviews of staff and residents, and observed by the audit team during the facility tour.

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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The agency does do its own adminstative but not criminal investigations, unless a staff member is involved then the Office of Internal Affairs will investigate intandum with local law enforcement. The State of California Department of Corrections and Rehabilitation Division of Juvenile Justice requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Specialized training includes techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Investigating agencies are required to maintain documentation that agency investigators have completed the required specialized training in conducting 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)

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 agency has a written policy related to the training of medical and mental health practitioners who work regularly in its facilities. The training includes: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. At this time there are no medical staff at this facility who conduct forensic exams, however all have received PREA training. During interviews these staff, including the PREA Coordinator, demonstrated an understanding of the processes utilized by medical and forensic professionals.

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.

The agency/facility have not supplied the auditor with documentation to substantiate full compliance with this standard. However, updates have been initiated, and goals set, which may increase the likelihood of compliance with this standard by the next audit. The screening form being used during the onsite audit required changes in order to include all the minimum screening requirements listed below. This updated form has to be approved and implemented: a process not fully completed during the 180 day Corrective Action Period as hoped. DJJ has a policy that requires screening (upon admission to the facility or transfer from another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. Such assessments shall be conducted using an objective screening instrument, which has been developed. At a minimum, the agency shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. This information is ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Controls are in place on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Also, the facilty is to reassess residents including any new information regarding risk factors that come to their attention after admission.

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 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 agency/facility have not supplied the auditor with documentation to substantiate full compliance with this standard because it relies on the screenings completed as per § 115.341 above. When those screenings are done, the information is to be used to inform housing, bed, work, education, and program assignments, and can be verified. No bed or program assignments are to be made unless a screener, or someone with access to the screening information, is consulted. The facility policy prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Proposed policy has been updated to assure the facility makes housing and program assignments for transgender or intersex residents on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

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.

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. This is accomplished though several options including the Office of Internal Affairs, Office of the Inspector General, and Sexual Misconduct Reporting Line. There are no residents detained solely for civil immigration purposes at this time. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports by the end of their shifts. The facility does provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency has also established procedures for staff to privately report sexual abuse and sexual harassment of residents. Residents interviewed indicate they know how to report sexual abuse and harassment.

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.

According to PREA Coordinator Dr. Paul Woodward, the facility has an administrative procedure for dealing with resident grievances regarding sexual abuse. He states in the Pre Audit Questionnaire that the policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The facility's policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. The facility has policy that requires a decision on the merits of any grievance or portion of a grievance alleging sexual abuse within 90 days of the filing of the grievance. The facility notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. The facility policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. Policy requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Policy allows legal guardians of residents to file a grievance, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. The agency has a policy for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. These emergency grievances require an initial response within 48 hours and a final agency decision within 5 days. The agency has a policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

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.

The facility is required to provide residents access to outside victim advocates for emotional support services related to sexual abuse by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations. Interviews indicated staff and residents are not informed, or are unclear, about services outside the facility, and confuse advocacy phone numbers with reporting numbers. Also, statements made to the audit team during interviews indicate that since there are mental health providers in place within the facility, some staff, including some of these mental health staff, do not find the access to outside support services to be all that necessary at NACYCF. There has been one allegation in the past 12 months but the auditor was not provided verification that outside confidential support services were appropriately offered/provided in that case. The facility has an MOU with San Jaoquin General Hospital for Forensic Medical Examinations and has developed an understanding with Youth and Family Services, a local crisis center, to provide victim advocates and supportive services including an 800 number the youth can call confidentially. These organizations were contacted by the auditor and the availability of services verified. The facility has recently improved their postings around the facility to assist in informing residents of these services, but it does not appear the facility has shown full compliance with this standard.

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.

The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment by phone, email, in writing, and by personal contact. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents, and assures the auditor this information will start being provided on the agency website as well.

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.

Interviews with staff and administrators, as well as a review of draft policy, verify that all staff are required to report immediately: Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. They also must report any retaliation against residents or staff who reported such an incident. They must report staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health professionals are required to report sexual abuse to designated supervisors, as well as to the designated State or local services agency required by mandatory reporting laws. Such practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility head or his or her designee is required to promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report is be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. The facility is required to report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, for investigation. The auditor cannot verify these reporting requirements are being followed since he was not permitted to see the documentation of this standard being followed in real life, in actual cases. Also, PREA Coordinator Dr. Paul Woodward states the retaliation requirement is not yet coded in officially approved policy. Updates provided during the Corrective Action Plan indicate progress is being made and the policies are nearly approved, which will trigger distribution, training, implementation, and the other steps to bring the facility into full compliance.

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.

When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Interviews indicate staff take this responsibility very seriously. In the past 12 months, there was one time the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse and they took immediate action.

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.

Agency policy requires that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director must notify the head of the facility where sexual abuse is alleged to have occurred, as well as notifying the appropriate investigative agency. In the past 12 months, one allegation has been received from another facility, according to the Pre Audit Questionnaire. The agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. Policy also requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. By agreement, this standard was included in the Corrective Action Plan (CAP) but the auditor did not receive verification of full compliance with this standard.

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.

The agency/facility has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: separate the

alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Interviews with the staff went well regarding this standard and they seem to generally understand their first responder duties although they don't have to use them very often. They hope they will remember these duties when they need to follow them. They work in various housing units over time and do not always know where these duties could be located and referred to. Also, the audit team did not find documentation where the duties have been distributed, or any statement of understanding signed by the staff. In addition, the auditor has not been able to review enough information regarding the allegation(s) received and investigation(s) conducted in the past 12 months in order to verify that first responder duties were followed in practice. There was at least one allegation/suspicion that a resident was sexually abused by a staff member, but the auditor has not been able to review documentation of First Responder steps that may have been initiated, taken, or attempted, in that case. This standard was included by agreement in the Corrective Action Plan (CAP), but the audit team did not receive verification that the text of the duties are readily available to staff, and being followed.

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 developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership, and this was provided to the auditor. They have listed specific medical facilities and advocacy organizations available in the event they have an allegation 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)

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.

DJJ has a Collective Bargaining Contract and maintains its ability to protect it's residents and employees from abusers.

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.

The agency/facility did not supply the auditor with documentation to substantiate compliance with this standard in practice. However, DJJ appears to have a proposed written policy to protect all residents and staff or any cooperating individual who reports sexual abuse or sexual harassment, or cooperates with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. Staff member(s) or department(s) are charged with monitoring for possible retaliation. They are to monitor the conduct or treatment of residents or staff who reported sexual abuse, and of residents who were reported to have suffered sexual abuse, to see if there are any changes that may suggest possible retaliation by residents or staff. They are required to examine resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. In the case of residents, such monitoring will also include periodic status checks. The agency/facility is required to act promptly to remedy any such retaliation. The agency and facility agreed, as part of the Corrective Action Plan (CAP) to provide a retaliation monitoring log or other documentation verifying this standard has been followed, however, the audit team did not receive this documentation.

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.

The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. According to interviews and PreAudit documentation provided, in the past 12 months no residents who have alleged sexual abuse have been placed in isolation or segregated for their protection. Assistant Superintendent Craig Watson explained it this way: They adequate options and resources at their disposal that they never have to move the victim. They don't have protective custody for victims. They move the others, those who might pose a threat. They might even be able to send an offender to county jail.

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.

DJJ has a proposed policy related to criminal and administrative agency investigations. The agency should not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are to be referred for prosecution. When the quality of evidence appears to support criminal prosecution, the investigative agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness should be assessed on an individual basis and not be determined by the person's status as resident or staff. No polygraphs are required. Administrative investigations, conducted by the agency include an effort to determine whether staff actions or failures to act contributed to the abuse. Investigations are to be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The agency is to retain all written reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention. The departure of the alleged abuser or victim from the employment or control of the facility or agency should not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility should cooperate with outside investigators and endeavor to remain informed about the progress of the investigation. The auditor could not verify full compliance with the standard since he was not provided documentation related to these standards being followed in actual practice. PREA standard 115.401 requires the auditor to review investigations. The auditor was provided one partial investigation which does not show this standard is being complied with in practice. The Corrective Action Plan (CAP) included this standard and was developed in coordination and consultation with the facility as well as with the agency PREA Coordinator. The auditor reached out to the agency PREA Coordinator by email on December 22, 2016, explaining that adequate documentation had not been received. Dr. Woodward replied, explaining, ". . . the majority of the items in the CAP are dependent upon implementing the updated PREA policy . . . . There are a few small items we can provide updates on that will help some, but I fear that without a few months of an implemented PREA policy under our belts, we will not have sufficient proof of practice to provide you." The auditor received no additional information regarding compliance with this standard.

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.

Written policy and some of the interviews conducted indicate the agency imposes a standard of a preponderance of the evidence, or a lower standard of proof, when determining whether allegations of sexual abuse or sexual harassment are substantiated. The auditor does not know what standard of proof is in actual practice by the agency's investigators since he was not allowed to view actual investigative documentation that shows how investigators arrive at their findings. The Corrective Action Plan (CAP) included this standard and was developed in coordination and consultation with the facility as well as with the agency PREA Coordinator. The auditor reached out to the agency PREA Coordinator by email on December 22, 2016, explaining that adequate documentation had not been received. Dr. Woodward replied, explaining, ". . . the majority of the items in the CAP are dependent upon implementing the updated PREA policy . . . . There are a few small items we can provide updates on that will help some, but I fear that without a few months of an implemented PREA policy under our belts, we will not have sufficient proof of practice to provide you." The auditor received no additional information regarding compliance with this standard.

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 requires that any resident who makes an allegation that he suffered sexual abuse is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. In the past 12 months there may have been a criminal and/or administrative investigation of alleged resident sexual abuse that was completed by the agency/facility. The auditor needed to be provided this documentation in order to determine whether the facility is fully compliant with this standard. By agreement, this requirement was part of the 180 day Corrective Action Plan (CAP), but the documentation was not provided to the auditor. Otherwise, the agency and facilty appear to be compliant with this standard. Policy and procedure indicates that if an outside entity conducts investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The proposed policy also requires that following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: The staff member is no longer posted within the resident's unit; The staff member is no longer employed at the facility; The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented. This documentation should be provided to an auditor during an audit in order for the auditor to be able to verify compliance.

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.

According to the policy provided for review, and according to interviews conducted, and the Pre-Audit Questionnaire, facility staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months one staff from the facility was alleged to have engaged in an inappropriate relationship with a youth. Since the auditor was not provided with the investigation of this allegation, or complete documentation regarding how this was handled, the auditor does not know what happened and therefore cannot verify full compliance with this standard. The Corrective Action Plan (CAP) included this standard and was developed in coordination and consultation with the facility as well as with the agency PREA Coordinator. The CAP called for copies of investigations to be provided to the auditor by August 17, along with any relevant staff disciplinary actions, and for monthly updates regarding progress being made toward compliance with this standard. The auditor reached out to the agency PREA Coordinator by email on December 22, 2016, explaining that adequate documentation had not been received. Dr. Woodward replied, explaining, ". . . the majority of the items in the CAP are dependent upon implementing the updated PREA policy . . . . There are a few small items we can provide updates on that will help some, but I fear that without a few months of an implemented PREA policy under our belts, we will not have sufficient proof of practice to provide you." The auditor received no additional information regarding this standard. The proposed policy appears to be consistent with PREA: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Policy and procedure also requires that terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any

relevant licensing bodies.

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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. According to interviews and documentation provided to the audit team the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by 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.

Since the auditor was not provided complete documentation of the investigations that were conducted regarding allegations of sexual abuse and harassment at the facility, the auditor cannot verify compliance with this standard. The auditor does not know what disciplinary sanctions have been utilized, if any. There was an allegation received during the past 12 months alleging an inappropriate relationship between a staff and a youth. The auditor was unable to obtain adequate documentation to show the conditions under which the youth recanted or whether that youth has been disciplined or isolated since making this allegation. However, despite the lack of documentation provided for the audit team to review regarding specific incidents and cases, policy reviews and interviews indicate the following as general practice: Residents are subjected to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse. Isolation is not used at the facility except for crisis management. Youth can be maintained in their single occupancy rooms. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician, and have access to other programs and work opportunities to the extent possible. According to Pre Audit documentation provided to the auditor, in the past 12 months no residents have been placed in isolation as a disciplinary sanction for resident-on resident sexual abuse. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. The Agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency

prohibits all sexual activity between residents and disciplines residents for such activity, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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.

Interviews indicate residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to ß 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. The auditor is told that mental health staff maintain secondary materials documenting compliance with the above required services. The information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

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.

Since the auditor could not review adequate investigatory documentation, he cannot determine whether resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, or whether the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Interviews indicate that medical and mental health staff at NACYCF maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. However, none of this was made available for the auditor to verify. Treatment services are to be provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident, but again, this documentation was not made available to the audit team. This was addressed in the Corrective Action Plan (CAP) which was developed in coordination and consultation with the facility as well as the agency. The CAP called for copies of investigations, and other documentation relevant to this standard, to be provided to the auditor by August 17, and for monthly updates regarding progress being made toward compliance with this standard. The auditor reached out to the agency PREA Coordinator by email on December 22, 2016, explaining that adequate documentation had not been received. Dr. Woodward replied, explaining, ". . . the majority of the items in the CAP are dependent upon implementing the updated PREA policy . . . . There are a few small items we can provide updates on that will help some, but I fear that without a few months of an implemented PREA policy under our belts, we will not have sufficient proof of practice to provide you." The auditor received no additional information to help verify compliance with this standard.

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.

Agency policy (not finalized) states the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. The facility has identified one person under its care in the past 12 months who may have been victimized by a staff member while in confinement. Interviews indicate the youth has been provided care, but it is not known what kind of care he received or whether he was offered or received the services specifically listed in this policy and standard. It is not known if the allegation was properly investigated. Partial documentation given to the auditor indicates the youth recanted and that "No Prea is warranted." In order to know whether this standard is being followed, the auditor needed to know the outcomes of any investigation(s) and view additional documentation that could explain the circumstances. The Corrective Action Plan (CAP) was developed in coordination and consultation with the facility as well as the agency. The CAP called for copies of investigations to be provided to the auditor by August 17, and for monthly updates thereafter regarding progress being made toward compliance with this standard. The auditor reached out to the agency PREA Coordinator by email on December 22, 2016, explaining that adequate documentation had not been received. Dr. Woodward replied, explaining, ". . . the majority of the items in the CAP are dependent upon implementing the updated PREA policy . . . . There are a few small items we can provide updates on that will help some, but I fear that without a few months of an implemented PREA policy under our belts, we will not have sufficient proof of practice to provide you." The auditor received no additional information regarding this standard.

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.

Policy requires that the facility/agency conduct a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. The facility is to conduct a sexual abuse incident review within 30 days of the conclusion of criminal or administrative sexual abuse investigations. The sexual abuse incident review team is to include upper-level management officials and is to allow for input from line supervisors, investigators, and medical or mental health practitioners. The review team is to consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. This team is to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was

motivated or otherwise caused by other group dynamics at the facility. It is to examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepare a report of its findings, including, but not necessarily limited to, determinations made pursuant to this section, and any recommendations for improvement, and submit such report to the facility head and PREA compliance manager. The facility is to implement the recommendations for improvement, or document its reasons for not doing so. In attempting to verify that this policy is being practiced in reality at the facility, the auditor needed to know whether there have been any investigations. Some documentation provided, and interviews, indicated there have been no need for any incident reviews because there have been no investigations. However, the auditor was supplied with an allegation made by a resident against a staff member. The allegation had been assigned to an investigator. This was not accompanied by a report of investigation but by a summary of conversations held with the resident until the resident eventually recanted his allegation. Also with the paperwork was a statement made by the investigator that "there was no sexual contact" by the staff member. Then it stated: "No Prea is warranted." The agency acknowledged that additional documentation was in existence regarding this allegation. Despite numerous requests, during the audit, and despite this being included in the Corrective Action Plan (CAP), adequate information was not provided to the audit team. It may be that an incident review should have been held regarding this investigation, or it may be that additional information would indicate no incident review was required. In order for the auditor to verify compliance with this standard, the auditor would have had to review the documentation that was not made available to the auditor, such as the Report of Investigation, or other documentation that would have clarified the circumstances.

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 agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency aggregates the incident-based sexual abuse data at least annually. The facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. DJJ obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The agency can provide the Department of Justice with data from the previous calendar year upon request. The auditor was provided with policy and some data applicable to this standard, but data have not been incorporated in public reports as required in ß115.388 and ß115.389. It should also be noted that the data may not be dependable or complete until the facility is in compliance with the documentation requirements of ß115.361 and ß115.363.

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.

According to interviews conducted and policy reviewed by the auditor, the agency plans to review data collected and aggregated pursuant to ß115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report is to include a comparison of the current year's data and corrective actions with those from prior years. Annual reports are to provide an assessment of the agency's progress in addressing sexual abuse. The agency plans to make its annual report readily available to the public at least annually through its website and through other means. The annual reports are to be approved by the agency head. When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. Agency PREA Coordinator Dr. Paul Woodward states the annual report has not yet been issued, but may be released soon. Since it has not been provided to the auditor, and the 180 Day Corrective Action Plan (CAP) has ended, the auditor cannot verify compliance with this standard.

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.

According to the policy the auditor reviewed, although it might be draft policy, the facility ensures that incident-based and aggregate data are securely retained. The policy requires that aggregated sexual abuse data be made readily available to the public, at least annually. The policy further requires that before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise. Since the auditor was not able to verify that this information has been made available to the public at the time of the on-site audit, this standard was included in the Corrective Action Plan (CAP). To the auditor's knowledge, this information still has not been compiled and made available to the public at the time of the conclusion of the Corrective Action Period.

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.

D. Will Weir _ 02/02/2017

Auditor Signature Date