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 13, 2016			
Facility Information			
Facility name: Pine Grove Youth Conservation Camp			
Facility physical address: 13630 Aquadect-Volcano Rd.; Pine Grove, CA 95665			
Facility mailing address: *(if different from above)* POB 1040; Pine Grove CA 95665			
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: Alicia Ginn			
Number of staff assigned to the facility in the last 12 months: 40			
Designed facility capacity: 80			
Current population of facility: 64			
Facility security levels/inmate custody levels: Low			
Age range of the population: 17-23			
Name of PREA Compliance Manager: Jim Liptrap		**Title:** Lieutenant	
Email address: Jim.Liptrap@cdcr.ca.gov		**Telephone number:** 209-296-7581	
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; Elkgrove 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	

AUDIT FINDINGS

NARRATIVE

PREAmerica LLC was retained on 03-21-2016 to perform the Pine Grove Youth Conservation Camp (PGYCC) PREA Audit by California Contract Manager Richard Zeunges. California PREA Juvenile Coordinator and Program Manager Paul Woodward scheduled the audit. Notices of the on-site audit went up by 04-22-2016 and the Pre-Audit Questionnaire was received June 3, 2016. The on-site audit was conducted as planned on June 13. PREAmerica Auditor Will Weir and Project Manager Tom Kovach met with Agency Juvenile PREA Coordinator Dr. Paul Woodard and Lt. Jim Liptrap (the PREA Compliance Manager) and were given a tour of the facility. The audit team was provided with rosters of residents and staff and conducted random interviews with residents and staff. The audit team interviewed a total of 10 staff, including specialized and administrative staff, and including all shifts. All 11 residents randomly selected were interviewed. The audit team were impressed by the professionalism of the staff, and the positive morale of the residents who generally indicated that they feel safe being at Pine Grove. The staff seem well trained. If they didn't have an answer memorized, they knew where to find the information. The camp is well organized and information is always located where it is supposed to be, according to interviews. Staff indicate a high level of job satisfaction getting to work in a program that seems to be making such a difference in the lives of residents who regularly go to work in well paying jobs upon discharge. The youth typically find it an honor to be at Pine Grove and appreciate the opportunity to learn a trade and be in such beautiful surroundings. From their perspective, sexual abuse is unlikely because nobody wants to be kicked out of the program that is seen as a valuable opportunity to gain marketable employment skills, references, and connections. This is not to mention that young people at high risk of being abusive may not pass screening requirements to be sent into the camp. The Exit Conference was attended by DJJ PREA Coordinator Dr. Paul Woodward, PGYCC Superintendent Alicia Ginn, and PREA Compliance Manager Lieutenant Jim Liptrap, with agency Deputy Director Anthony Lucero joining by speaker phone. During the conference, the attendees discussed the areas for improvement (see below), as well as the various strengths and attributes of the program. The audit team expressed appreciation for the efficient way the staff assisted with the audit and the respect shown for the process.

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 5 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; §115.341 & §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; 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 5 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 Division of Juvenile Justice (DJJ) maintains a youth conservation camp at Pine Grove in Amador County. It screens and accepts low risk classification youths from other DJJ facilities. Training is provided by CAL Fire (formerly CDF) and youths are certified to engage in wild land firefighting operations. Fire crews from DJJ camps perform approximately 180,000 hours of fire suppression services in a "normal" year for the people of California.

Crews typically work in state and county parks performing stream clearance, wild land fire prevention tasks, and restoration work. During the fire season, youth crews are involved in wild land fire suppression throughout the state of California. Camp crews are also assigned to flood control activities. The major emphasis of the camp programs is to provide youths with employability skills and to develop a strong emphasis on solid work habits. In addition, youths receive leadership training within their crew structure.

The education programs take place in the evening hours. All non-high school graduates participate in GED preparation or a high school skill level program. The academic goal is completion of educational requirements for normal entry-level employment. Each camp also has a formal drug program offering various treatment modalities.

The Camp has 14 buildings including 1 dormstyle housing unit with 2 bays and a central control area. There is also an adminstration building, school building, maintenance shop, equipment storage, and kitchen. There are no cameras.

SUMMARY OF AUDIT FINDINGS

Pine Grove Youth Conservation Camp received its onsite PREA Audit on June 13, 2016. The facility was able to demonstrate compliance with 35 PREA Standards and had 5 additional standards to demonstrate compliance with during the 180 day Corrective Action Plan (CAP) which was developed in coordination with facility administrators, the audit team and the DJJ PREA Coordinator. The facility did not show compliance with any additional standards during the CAP.

Number of standards exceeded: 0

Number of standards met: 35

Number of standards not met: 5

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 (Lt. Liptrap) 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.

PGYCC 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. PGYCC documents unannounced rounds on all shifts with a prohibition of staff alerting other staff of the conduct of the rounds.

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 when youth were in showers in clear sight of the control center without privacy barriers. Curtains and barriers were, by agreement, to be installed during the Corrective Action Period but the auditor received no verification of this. 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 established policy indicates 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 policy 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 2 contract persons have been hired who may have contact with residents who 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 not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. The facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. Documentation provided, as well as interviews with administrators, indicate PREA will be considered when updates occur.

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 Amador County Sherrif's Department 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 criminal investigative responsibilities, as does the agency in 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 all 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 Stockton. 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. 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 documented. If they are not available to provide victim advocate services, the facility provides a qualified staff member.

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.

According to interviews conducted and policies reviewed, the facility and the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past 12 months 0 allegations of sexual abuse or sexual

harassment were received, so the auditor could not review any allegations or investigations. The agency has a policy requiring 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 is required to document all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

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 all 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. 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)

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.

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 and the Pre-Audit documentation, 5 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)

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.

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)

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 typically 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 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. Documentation reviewed, and interviews with administrators, verify that PGYCC does investigate sexual abuse allegations at this time, and cooperates with authorities, and collects information needed to make determinations regarding resident treatment and safety.

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. There are no medical staff at PGYCC who conduct forensic exams.

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 during 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. 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, so the portion of the standard dealing with this population does not apply. 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. Interviews indicated that a number of residents are confused as to the extent their calls are monitored and therefore were not sure they can report privately. The audit team verified that they can make reports privately. The superintendent and PREA Coordinator have agreed to make sure all residents know they can report without their call being monitored. To be clear, the residents with this concern stated they had nothing they needed to report and that they generally feel free to approach staff. They know they can report to staff and feel safe at PGYCC, which, according to them, is one reason they have not paid attention to the extent to which their calls are monitored.

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 that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made 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 provides 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. The auditor verified the outside confidential support and advocacy services available to the residents. Since there have been no allegations in the past 12 months, the auditor was not able to review investigations to see whether outside confidential support services were offered; however, the auditor believes numbers for advocacy organizations have been provided to all residents.

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 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. Documentation was provided to the auditor that no investigations have been conducted at PGYCC, so there were no files for the auditor to review. This was verified during interviews at the facility.

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 were no times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DJJ 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. According to the Pre-Audit Questionnaire and interviews conducted during the onsite audit, no allegations have been received in the past 12 months that a resident was abused while confined at another facility. 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.

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 from the alleged perpetrator; preserve and protect any crime scene until appropriate steps could 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. In the past 12 months there was 0 allegations that a resident was sexually abused, according to documentation provided to the auditor. Staff indicate they understand first responder duties. Training logs and training curriculum indicate all duties are covered.

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.

DJJ has a 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. Lt. Liptrap, PREA Compliance Manager, is charged with monitoring retaliation at the facility. He monitors 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. He examines resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. He understands that his responsibilities require him to continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring will also include periodic status checks. The agency/facility acts promptly to remedy any such retaliation. No

incidents of retaliation have came to their attention during the past 12 months, according to interviews and documentation reviewed by the audit team.

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. This amounts to limited restraints and segregation rather than isolation since the facility is not a secure facility.
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. Although this is covered in policy, interviews indicate isolation is very unlikely to occur at Pine Grove. In the past 12 months no residents who have alleged sexual abuse have been placed in isolation or segregated for their protection.

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.

The Agency has a policy related to criminal and administrative agency investigations. All sections of this standard appear to have been added to the agency's written policies. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are 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 will 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. Criminal and Administrative investigations will 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, with copies of all documentary evidence attached to the reports when feasible. The agency will 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 will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation. The PREA Coordinator, PREA Compliance Manager, and OIG investigator interviewed, verify that these policies and procedures are in place. Even though changes to the PREA policy are being proposed, interviews indicate that basic investigative practices have been required many years, are in older versions of policy and are to remain intact.

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 interviews with administrators verify that 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.

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.

According to the policy provided for the auditor's review, the facility 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. According to Pre Audit information provided, in the past 12 months there have been 0 criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility, so the auditor was not able to review examples of these policies being followed. Policy and interviews conducted indicate that if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. 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. It is required that all notifications to residents described under this standard are documented.

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 no staff from the facility was alleged to have violated agency sexual abuse or sexual harassment policies, so the auditor was unable to review any actual disciplinary sanctions allowed for under this standard. 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. All 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. In the past 12 months, since there have been no allegations, there have been no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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, since there were no such allegations or findings. The facility takes appropriate remedial measures, according to policy and interviews, 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.

Policy review and interviews indicate: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. In the past 12 months there have been no findings of resident-on-resident sexual abuse that have occurred at the facility. Isolation is not used at the facility except for short term crisis management until other help can arrive. 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, but again, the resident would not remain at the facility and would be moved to a facility with a higher level of care. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12 months no residents have been placed in isolation as a disciplinary sanction for resident-on resident sexual abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility 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.

According to policy, all 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. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. 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. 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. Documentation received by the auditor, and interviews conducted, indicate that the infrastructure is in place to follow this policy, although since PGYCC is a camp, some services may be provided off site, or by DJJ staff who are not housed at the facility full time, depending on the need and available services. Mental and mental health staff also work at the DJJ facilities the youth are placed in prior to being assigned to PGYCC, and do these screenings at those facilities as well.

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.

According to policy, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff 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. Treatment services are 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. According to documentation provided to the auditor, and interviews conducted, no residents at PGYCC were alleged to have been sexually abused in the past year, and so none required the emergency care provided for in this policy. Residents and staff interviewed indicated a belief that appropriate care would be provided if needed.

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.

Policy requires that the facility offer 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. Documentation received, and interviews conducted, do not indicate any residents of PGYCC have required these services in the past year. Since PGYCC is a camp, some services required by this standard may be provided off site.

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 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. Even though there have not been any investigations and therefore no incident reviews, the facility is to conduct a sexual abuse incident review within 30 days of the conclusion of a criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation

indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; considers 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; examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assesses the adequacy of staffing levels in that area during different shifts; assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepares a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submits such report to the facility head and PREA compliance manager. The facility implements the recommendations for improvement, or documents its reasons for not doing so.

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 data satisfying this standard, although it has not been incorporated in public reports as required in 115.388 and 115.389.

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. The auditor received no information or updates regarding progress toward compliance with this standard despite the Corrective Action Agreement indicating that the auditor would receive monthly progress reports beginning September 1, 2016, until the compliance was achieved.

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