Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report January 2, 2019

Auditor Information

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Company Name: PREA America LLC	
Mailing Address: P. O. Box 1473	**City, State, Zip:** Raton, NM 87740
Telephone: 405-945-1951	**Date of Facility Visit:** 04-24-2018

Agency Information

Name of Agency Division of Juvenile Justice (DJJ)	**Governing Authority or Parent Agency** *(If Applicable)* California Department of Corrections & Rehabilitation (CDCR)
Physical Address 8260 Longleaf Drive (mailroom)	**City, State, Zip:** Elk Grove, CA 95758-8501
Mailing Address: P. O. Box 588501	**City, State, Zip:** Elk Grove, CA 95758-8501
Telephone: 916-683-7452 (Director's Secretary)	**Is Agency accredited by any organization?** ☐ Yes ☒ No

The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: To provide opportunities for growth and change by identifying and responding to the unique needs of our youth. We do this through effective treatment, education and interventions in order to encourage positive lifestyles, reduce recidivism, strengthen families and protect our communities.

Agency Website with PREA Information: https://cdcr.ca.gov/PREA/index.html
https://cdcr.ca.gov/juvenile_justice/prea/

Agency Chief Executive Officer

Name: Chuck Supple	**Title:** Director
Email: chuck.supple@cdcr.ca.gov	**Telephone:** 916-683-7451

Agency-Wide PREA Coordinator	
Name: Dr. Jonathan Yip, Ph.D.	**Title:** Associate Director of Mental Health
Email: Jonathan.Yip@cdcr.ca.gov	**Telephone:** 916-683-7760
PREA Coordinator Reports to: Dr. Heather C. Bowlds, Psy.D., Deputy Director	**Number of Compliance Managers who report to the PREA Coordinator** 4

Facility Information

Name of Facility: N. A. Chaderjian Youth Correctional Facility				
Physical Address: 7650 S. Newcastle Road; Stockton, CA 95213-9014				
Mailing Address (if different than above): P. O. Box 213014; Stockton, CA 95213-9014				
Telephone Number: 209-944-6188				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other

Facility Mission: To provide opportunities for growth and change by identifying and responding to the unique needs of our youth. We do this through effective treatment, education and interventions in order to encourage positive lifestyles, reduce recidivism, strengthen families and protect our communities.

Facility Website with PREA Information https://cdcr.ca.gov/PREA/index.html https://cdcr.ca.gov/juvenile_justice/prea/ https://cdcr.ca.gov/Juvenile_Justice/PREA/Reports-Audits.html

Is this facility accredited by any other organization? ☐ Yes ☒ No

Facility Administrator/Superintendent	
Name: Linda Bridges	**Title:** Superintendent
Email: Linda.Bridges@cdcr.ca.gov	**Telephone:** 209-944-6301

Facility PREA Compliance Manager	
Name: Mark Miranda	**Title:** Treatment Team Supervisor
Email: Mark.Miranda@cdcr.ca.gov	**Telephone:** 209-944-6188

Facility Health Service Administrator			
Name: Fernando Campos		**Title:** Health Care Services Administrator	
Email: Fernando.Campos@cdcr.ca.gov		**Telephone:** 209-944-6579	
Facility Characteristics			
Designated Facility Capacity: 600		**Current Population of Facility:** 194	
Number of residents admitted to facility during the past 12 months			318
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			318
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			318
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	15-23		
Average length of stay or time under supervision:			24 months
Facility Security Level:			
Resident Custody Levels:			Low, Low Moderate, Moderate, Moderate High, High, Very High
Number of staff currently employed by the facility who may have contact with residents:			315
Number of staff hired by the facility during the past 12 months who may have contact with residents:			45
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			257
Physical Plant			
Number of Buildings: 24		**Number of Single Cell Housing Units:** 12	
Number of Multiple Occupancy Cell Housing Units:		0	
Number of Open Bay/Dorm Housing Units:		0	
Number of Segregation Cells (Administrative and Disciplinary:		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): Video monitoring throughout the facility is limited and could benefit from updates and enhancements.			
Medical			
Type of Medical Facility:		Outpatient Housing Unit (OHU)	

Forensic sexual assault medical exams are conducted at:	San Joaquin County Hospital
Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	17
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	4

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

PREA America LLC was retained on August 7, 2017 to perform the PREA Audit of the N. A. Chaderjian Youth Correctional Facility (alternatively known as NAC, NACYC, or Chad) by California Contract Manager Richard Zeunges. CDCR DJJ PREA Analyst Rosemary Carrillo and DJJ PREA Coordinator Dr. Jonathan Yip coordinated with the audit team to prepare for the audit. Notices of the on-site audit went up by March 12, 2018. The Pre-Audit Questionnaire, and the first set of supporting documents, were received by the auditor on 04-09-2018. Additional organized clusters of supportive documentation were provided to the auditor at regular intervals through 04-20-2018. The on-site audit was conducted April 24, 2018. Some important additional documentation was provided during the onsite audit and in the weeks that followed. The audit team arrived the morning of April 24th and met, for an introductory conference, with key administrators, including Superintendent Linda Bridges, PREA Coordinator Jonathan Yip, PREA Compliance Manager Mark Miranda, and PREA Analyst Rosemary Carrillo.

After introductions, the audit team went on a facility tour and started interviews. 26 of the 194 residents at the facility were interviewed. The residents interviewed were composed of 16 random and 10 targeted interviews and represented every housing unit. A total of 28 formal staff interviews were conducted for this audit. This includes specialized staff, and it also includes the phone interview with Deputy Director Heather Bowlds. This number does not include informal interviews that were conducted along the way, and the interviews with the SANE Nurse Administrator and interviews conducted to verify advocacy services available to the residents. Numerous staff and supervisors assisted the on-site audit process to flow smoothly and efficiently. At the end of the day, the exit conference was attended by the audit team and by PREA Coordinator Jonathon Yip, Program Administrators Paul Woodward and Karen Heintschel (who have previously served as agency PREA Coordinators), PREA Compliance Manager Mark Miranda, Supervisors Michael Trotter and Rob Dulces, Superintendent Linda Bridges, and PREA Analyst Rosemary Carrillo.

The exit conference covered a variety of topics, including strengths and challenges. The agency seems to have a strong, well-organized training program, which is up to the challenge of getting everyone

trained on all policy changes and updates. However, attaining this goal takes time, and trainings planned at the agency level sometimes have to be put on hold until policies are approved at the state level. Interviews indicated staff and supervisors had a strong grasp of the First Responder Duties, minus some details. Another example of something currently being rectified in training is the prohibition against cross-gender pat-down searches of male residents absent exigent circumstances, and the need to document any cross-gender searches that occur. Another topic discussed in the conference was showers. There are differences from housing unit to housing unit regarding resident showers. Although residents did not express concerns about this to the audit team, areas were identified by staff and the audit team where accidental lack of privacy might occur during cross-gender supervision. Although no current transgender residents have been identified, improving the privacy in these same showers will likely reduce risks of privacy violations for these residents as well.

In post exit conference visits and emails, Dr. Yip and Ms. Carrillo updated the auditor about agency-wide issues to be addressed in the Corrective Action Plan. The agency is updating their system of performing employee background searches to assure that Child Abuse Central Index (CACI) checks are conducted as required for potential employees. Also, as facility document reviews were completed, additional facility issues were identified. The documentation regarding the monitoring for retaliation may have been misplaced, so it still needed to be reviewed by the auditor, as well as some documentation regarding reporting to alleged victims regarding the outcomes of investigations. Sexual abuse incident reviews had been on hold, pending policy revisions and forms being updated; so, these needed to be conducted, then audited. The auditor provided the agency with the PREA Audit Interim Report on June 7, and continued work on the CAP, with drafts going back and forth in July, with some additional modifications in August. The agency and facility turned in documentation to the auditor until the week before the 180th day. (The PREA Standard is to not allow CAP's to last more than 180 days past the date of the Interim Report.) The agency/facility ultimately showed compliance with all but 3 PREA Standards. There is a Summary of Audit Findings on page 7 of this report, and then there are narratives regarding compliance with each numbered PREA Standard in the pages that follow.

Documentation reviewed includes: NACYC PAQ; Schematic Layout of Facility; PREA Policy; Mission & Guiding Principles; DJJ Organizational Chart, identifying PREA Coordinator; Conduction of Searches Policy; Volunteer Contractor Informational Sheet (DJJ8.137 form); PREA Screening Tool (DJJ8.138 form); Average Daily Population & Budgeted Population (for past year); Treatment Intervention Program Policy; Youth Grievance Policy; Reporting Suspected Child Abuse or Neglect Policy; Treatment Confidentiality Policy; PREA Training Curriculum; PREA Refresher Training; PREA Knowledge Review, Glossary & References; PREA Refresher IG; Access to Youth Files & Info by Legal counsel & Authorized Representatives; Staff Misconduct Complaint Policy; Youth Sexual Misconduct Complaint Policy; Acknowledgements and records of training; Survey of Sexual Victimization-Incident Juvenile (SSV-IJ); DJJ 8.130 Initial PREA Contact Guide; DJJ 8.129 Custody Supervisor PREA Checklist; DJJ 8.132 Watch Commander PREA Notification Checklist; DJJ 8.131 PREA Transportation Guide; DJJ 8.135 Sexual Assault Interview Guidelines; DJJ 8.134 Protection Against Retaliation (PAR) – Youth; DJJ 8.133 Protection Against Retaliation (PAR) – Staff; DJJ 8.143 Victims of Sex Crimes – Attachment C; DJJ 8.138 PREA Screening Tool; DJJ 8.141 Record of PREA Education; DJJ 8.140 Notice of Unusual Occurrence (PREA); DJJ 8.144 PREA Search Alert Preference Question(s); DJJ 8.137 Volunteer/Contractor Informational Sheet (PREA); PREA Policy (Revised 04-10-2018); Survey of Sexual Victimization; DJJ_8.496 Staff Misconduct Complaint; DJJ_8.143_PREA Victims Of Sex Crimes form; DJJ_8.142 Search Alert (PREA); DJJ_8.235 Medical Report Of Unusual Occurrence Or Injury; DJJ_8.136 Victim-Restricted Information Deletion; DJJ 8.137 PREA Informational Sheet For Volunteers And Contract Employees; Staff and Resident Rosters; PREA Block Training-North 040517-121317 & 011018-022818; Resident Education documentation; PREA Brochure and Booklet for Youth during

PREA Orientation; Youth Rights Handbook; Specialized Training: Investigations; LDI Training sign-in sheet; Specialized PREA LDI Training Instruction Guide; Specialized PREA LDI Training Participant Workbook; Specialized PREA LDI Training Power Point; Specialized PREA LDI Training Knowledge Review (Key); Approved Standard Agreement on Forensic Examinations (2 parts); Supervision & Monitoring documentation: samples of Unannounced Rounds logs for all housing units; PREA Grievance; CN018 Wards with Disability Policy and Procedures; Personnel Identification Card Issuance Memorandum; CDCR 1951 Supplemental Application for All CDCR Employees; Justification Memorandum; Sexual Harassment Prevention Policy; Backgrounds Investigations Policy; Updated PAQ; Draft MOU with local rape crisis center (Women's Center Youth and Family Services); Drafts of a flyer with local rape crisis center (in draft and working to finalize); Samples PREA Screening Tools; Bargaining Unit 6 (BU6) contract; 2016 DJJ PREA Annual Report; Allegation Tracking sheet for 2017; Reports of Disposition and Review; and all investigations.

Additional documentation received and reviewed during Corrective Action Period (CAP):
Photos of completed shower privacy screens for each living unit (including non-operational units); Conducting Searches policy submitted to Labor Relations and then sent to labor unions (pending negotiation); PREA Labor Memo regarding changes to PREA and Conducting Searches policies; Child Abuse Central Index (CACI) Memo; Livescan CACI Training material – completed by Office of Peace Officer Selection unit; Livescan (CACI) Training records; CDCR form 3056 – Request for Live Scan Service reflecting new CACI option; Livescan applications Proof of Practice; PREA policy submitted to Labor Relations and then sent to labor unions (pending negotiation); First Responder guide; First Responder memo; Training Records for PCM Trotter on specific PREA Juvenile Standards; DJJ Form 8.139 – Notification to Youth [of investigative outcome] form; Quarterly PCM Meeting and Training Sign in Sheet – 8/15/18 that covers DJJ Form 8.139 and refresher on IPRC requirements; Quarterly PCM Meeting and Training Sign in and Agenda – 3/8/18 that addressed release of IPRC forms; Institutional PREA Review Committee template; Institutional PREA Review Committee completed document; photographs of the PREA First Responder guides placed at the YCC stations; POP training records; and emails detailing progress.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The N. A. Chaderjian Youth Correctional Facility is located in Stockton, in San Joaquin County, and houses male youths 15 to 23 years of age in living units comprised of individual rooms.

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

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

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

From agency website [paragraphs removed]: “The Division of Juvenile Justice provides education and treatment to California’s youthful offenders up to the age of 25 who have the most serious criminal backgrounds and most intense treatment needs. Most juvenile offenders today are committed to county facilities in their home community where they can be closer to their families and local social services that are vital to rehabilitation. As a result, DJJ’s population represents less than one percent of the 225,000 youths arrested in California each year. This population has committed serious and/or violent felonies that requires intensive treatment services conducted in a structured and secure environment. DJJ provides academic and vocational education, treatment programs that address violent and criminogenic behavior, sex offender behavior, and substance abuse and mental health problems, and medical care, while maintaining a safe and secure environment conducive to learning. Treatment is guided by a series of plans supervised by the Alameda Superior Court, as a settlement agreement in a lawsuit known as Farrell. Youth are assigned living units based on their age, gender, risk of institutional violence and their specialized treatment needs. The population in each living unit is limited and staffing levels ensure that each youth receives effective attention and rehabilitative programming. The framework for DJJ’s programs is the Integrated Behavior Treatment Model. It is designed to reduce institutional violence and future criminal behavior by teaching anti-criminal attitudes and providing personal skills for youth to better manage their environment. DJJ staff from every professional discipline work as a team to assess the unique needs of each youth and to develop an individualized treatment program to address them. Through collaboration with the youth, the team administers a case plan that takes advantage of each youth’s personal strengths to maximize treatment in other areas of their life to reduce the risk of re-offending.”

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.*

Number of Standards Exceeded: 0

Number of Standards Met: 40

Number of Standards Not Met: 3

Standard 115.317, Standard 115.367, and Standard 115.373

Summary of Corrective Action (if any)

Standard 115.315: Limits to cross-gender viewing and searches (RESOLVED)
The audit interviews conducted during, and leading up to, the on-site audit, indicated some cross-gender pat-down searches, absent exigent circumstances, still occurred, although rare. Also, this standard has a section regarding transgender searches that is in fully accepted in practice, but which has not yet been fully codified in policy as desired by the agency. Nothing in the old policy violates this standard or requires this standard to be violated. During the site review, some showers were observed to have limited privacy, which caused some discussion, because of cross-gender supervision privacy concerns and raising a potential issue regarding the privacy of transgender residents. **Corrective Action:** During the CAP, the facility addressed the concerns brought up by the audit team. The practice of conducting cross-gender searches has been declining for years, and it now has been fully discontinued. The new policy will more fully institutionalize the strict practices currently engaged, along with the updated documentation requirements regarding searches. Privacy screens have been added in needed areas.

Standard 115.317: Hiring and promotion decisions (NOT RESOLVED)
At the time of the Interim PREA Audit Report, the agency was updating the system of performing employee background searches to assure that Child Abuse Central Index (CACI) checks can begin, as required, for potential and existing employees. **Corrective Action:** On November 30, 2018, Dr. Yip, PREA Coordinator stated, "Not all NAC employees and contractors have been checked. All new employees, contractors and volunteers since the go-live of CACI are being checked." Considering the steps required to get the CACI process started and implemented, the agency has made great progress. However, they have not yet provided any completed CACI checks.

Standard 115.342: Use of screening information (RESOLVED)
At the time of the writing of the Interim Report, the auditor could not find verification that placement and programming assignments for each transgender or intersex resident are being reassessed at least twice each year to review any threats to safety experienced by the resident. The Transgender Youth policy is still being developed and is in draft form. **Corrective Action:** The Draft PREA Policies dated 03-01-2017 and 08-01-2018, explicitly require the practice of this standard, although the policies are still officially in "Draft" form. They state in Section 7 (a), "Within 48 hours of arrival at a DJJ facility, each youth shall be screened using the DJJ Form 8.138 PREA Screening Tool by their Parole Agent/Casework Specialist. Note: Each youth shall be re-assessed for risk of victimization or predatory behavior using the PREA Screening Tool whenever a new risk factor becomes known, within 48 hours of arrival at a new facility, and no less frequently than annually at youth's Annual Review. Placement for transgender or intersex youth shall be reassessed at minimum twice per year." The facility has no residents who identify as transgender at this time, so the auditor could not interview them or review their files or reassessments. However, the screening staff have been trained in this PREA Standard, and they do reassessments as required by the Standard. They can practice compliance with this standard without violating official agency policies, because the old policy contains nothing to discourage this practice. The way this PREA Standard is worded requires compliance in practice, but it does not explicitly require policy be written a certain way.

Standard 115.364: Staff first responder duties (RESOLVED)
At the time of the on-site audit and Interim Report, it was evident that DJJ has a clear First Responder policy for allegations of sexual abuse, but that not all staff understood First Responder Duties. Some staff and supervisors interviewed missed the difference between "requesting" the victim and "ensuring" the alleged abuser not destroy evidence. The Initial PREA Contact Guide inaccurately stated, "Ensure the victim and suspect, . . . [protect evidence]" The audit team verified, during the on-site audit (through interviews as well as during the

site review), that First Responders have been provided an accurate and relatively comprehensive tabulated and laminated PREA pocket guide, detailing these required responses, but a more effective heuristic approach to the implementation of the updated policy, and related forms for documentation of the responses, was in process, according to PREA Coordinator Yip. **Corrective Action:** During the CAP, the facility continued the update of the First Responder Duties through cards/guides issued to staff, notices posted where first responders will see them, and various trainings.

Standard 115.367: Agency protection against retaliation (NOT RESOLVED)
The agency had not shown documentation of compliance with this standard by the time the Interim Report was written. **Corrective Action**: By the end of the CAP, documentation of retaliation monitoring still had not been provided.

Standard 115.373: Reporting to residents (NOT RESOLVED)
The agency had not shown documentation of compliance with this standard by the time the Interim Report was written. **Corrective Action:** By the end of the CAP, documentation of notification of residents (regarding the outcomes of investigations) still had not been provided.

Standard 115.386: Sexual abuse incident reviews (RESOLVED)
The agency had not shown documentation of compliance with this standard by the time the Interim Report was written. **Corrective Action:** By the end of the CAP, documentation of a completed Incident Review had been provided.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy reviews and interviews with staff and residents verify this agency has a written policy, as well as an active practice, of mandating zero tolerance toward all forms of sexual abuse and sexual harassment. Organizational Charts help understand the system of accountability and chain of command in the agency, as well in the facility. This facility, N. A. Chaderjian Youth Correctional Facility (NACYCF, also sometimes called "Chad"), is operated by the California Department of Corrections and Rehabilitation's Division of Juvenile Justice (CDCR DJJ). The agency has 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 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. The agency employs an upper-level, agency-wide PREA coordinator. Dr. Jonathan Yip is the DJJ PREA Coordinator. The facility has designated a PREA Compliance Manager, Treatment Team Supervisor Mark Miranda, who coordinates the facility's efforts to comply with the PREA standards. Organizational charts show that CDCR is headed by Secretary Scott Kernan. Operations Undersecretary Ralph Diaz answers to Secretary Kernan. The Director of the Division of DJJ, Chuck Supple, answers to Undersecretary Diaz. The PREA Coordinator answers directly to Operations and Programs Deputy Director Heather Bowlds, who answers to Director Supple.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Interviews with the PREA Coordinator and PREA Compliance Manager; Reviews of the Zero Tolerance Policy, Organizational

Chart, and PREA Definitions. Also pertinent is the role the PREA Coordinator and PREA Compliance Manager has had, in demonstrating increased PREA compliance, in practice, during this audit.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A. The agency reports no contracts for the confinement of residents.

Analysis and Finding: Relevant interviews conducted, and documents reviewed, indicate the department houses its own residents. This standard applies to agencies who house residents in their

care with other agencies or entities. The agency/facility is considered to be in compliance with the standard, since there is no evidence that the standard applies or that it is violated.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N. A. Chaderjian Youth Correctional Facility has developed, documented, and appears to have made its best efforts to comply on a regular basis with, a staffing plan that considers all relevant factors, and provides adequate levels of staffing and seeks adequate levels of video monitoring, to protect residents against abuse. This is according to the Staffing Plan and related documents. The average daily number of residents has been 215, the same number on which the staffing plan was predicated. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. According to the Pre-Audit Questionnaire, interviews, and other documentation received by the auditor, there were no deviations from the plan in the past year. The facility's plan strives to maintain staffing ratios of a minimum of 1 staff to 8 residents during resident waking hours and 1 to 16 during resident sleeping hours. At least once every year, the agency or facility, 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. These rounds are documented and cover all shifts, according to logs provided and interviews conducted.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. Reviews of the following documents were conducted: documents related to staffing planning, with schedules and rosters and Average Daily Population & Budgeted Population; documentation of unannounced rounds for each housing unit; Institutions and Camps (I&C) PREA Policy; and PAQ. The following interviews also indicated compliance with this standard: Superintendent Linda Bridges, PREA Coordinator Jonathan Yip, PREA Compliance Manager Mark Miranda, PREA Analyst Rosemary Carrillo; Agency Deputy Director Heather Bowlds, and supervisors who schedule staff and do rounds.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that 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? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status 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? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The audit interviews conducted during, and leading up to, the on-site audit, indicated some cross-gender pat-down searches, absent exigent circumstances, were still occurring at that time, although rare. The agency-wide policy updates to prohibit cross-gender pat-down searches absent exigent circumstances (and to require documentation) had yet to be fully implemented. Also, this standard has a section regarding transgender searches that is in the Draft Transgender Youth Policy, which has not been fully approved for implementation. No inappropriate searches of transgender youth are alleged to have occurred, but the agency believes these protections should be fully codified in policy. Therefore, they stipulated to this being a corrective action item, to give more time for the agency to push forward toward these objectives. However, for DJJ, it is especially important to understand that nothing in the old policy violates this standard, nor requires this standard to be violated. During the site review, some showers were observed to have limited privacy, which caused some discussion around cross-gender supervision privacy concerns, and which raised a potential issue regarding the privacy of transgender residents. Residents were not complaining regarding these showers, but staff, administrators, and the audit team identified some improvements to implement during the CAP, so that compliance with this standard would not be in doubt.

Corrective Action: Some policies are still officially labeled as being in "draft" form, because some approvals take years to be fully canonized within CDCR's bureaucratic system. Yet, during the CAP, the facility addressed the concerns brought up by the audit team and tried to move draft policies forward. Dr. Yip stated, on November 30, 2018, "No policy can be disseminated, implemented or trained until the labor process has completed." The areas where the "official policy" varies from the "draft policy" do not appear to constitute PREA violations, since both training and practice are now shown to be consistent with PREA. In no case does the official policy require PREA violations of this standard. In no instance does the existing official (pre-draft) policy fail to contain something the PREA Standard explicitly requires to be formalized in written policy. For example, the wording of the old policy is not as rigid regarding cross-gender pat searches being restricted only to exigent circumstances, but it discourages them. The practice of conducting cross-gender searches has been declining for years and now has been fully discontinued, absent exigent circumstances. The new policy will more fully institutionalize the strict practices currently in practice, along with the updated documentation requirements regarding searches.

Analysis: By a triangulation of evidence, the auditor has determined that the facility has shown compliance with this standard. This evidence is divided as follows:

1) Interviews: In all areas that interviews indicated possible lack of compliance with PREA standards, the agency has provided documentation that addresses those concerns, and which shows full compliance. This includes updated policies, notices, forms, brochures and trainings.
2) Site Review: In all areas (mentioned above) identified during the Site Review as possible violations, the facility has made updates and provided pictures for the auditor for review.
3) Documentation Review: The following documentation has been reviewed for PREA compliance: Photos of completed shower privacy screens for each living unit (including non-operational units); Conducting Searches policy submitted to Labor Relations and then sent to labor unions

(pending negotiation); PREA Labor Memo regarding changes to PREA and Conducting Searches policies; Training records and sign-in sheets; and updated (draft) PREA Policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on 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 §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 will typically assist residents to generally comprehend whatever it is necessary for residents to learn; and, that staff will certainly try to help them understand both their rights to be safe and what can keep them safe. Staff interviews and policy reviews indicate these efforts have been required and practiced in the agency culture for a number of years.

Analysis: By a triangulation of evidence, the auditor has determined that the facility has shown compliance with this standard. This evidence is divided as follows:
Interviews: Interviews with the following stakeholders support a finding that the facility and agency is compliant with this standard: Deputy Director Heather Bowlds, facility Superintendent Linda Bridges, facility PREA Compliance Manager Mark Miranda, PREA Analyst Rosemary Carrillo, random and targeted resident interviews, and random staff interviews.
Documentation: The following documentation is consistent with this standard: PREA Block Training; Resident Education documentation; PREA Brochure and Booklet for Youth during PREA Orientation; Youth Rights Handbook; and CN018 Wards with Disability Policy and Procedures.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone 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)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: 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? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of 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)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: 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? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider 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? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☐ Yes ☒ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make 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? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☐ Yes ☒ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency 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? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. DJJ policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks. However, the agency has not yet fully implemented the requirement to consult any child abuse registry maintained by the State or locality in which the employee would work. The agency, 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. 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. They have a system in place that gives them nearly instant notification of some types of arrests/convictions for their employees. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The agency provides 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. The audit team believes the agency follows this standard, except for being able to verify that they consult the Child Abuse Index maintained by the State of California Department of Justice regarding potential employees and contractors who might have contact with residents.

Corrective Action: On November 30, 2018, Dr. Yip, PREA Coordinator stated, “Not all NAC employees and contractors have been checked. All new employees, contractors and volunteers since the go-live of CACI are being checked.” Considering the steps required to get the CACI process implemented, the agency has made great progress. However, they have not yet provided any completed CACI checks.

Analysis: The auditor is not yet able, by a triangulation of evidence, to determine that the facility has shown compliance with this standard. Although they have made progress, and although they have policies and procedures in place, they have not yet been able to provide any completed Child Abuse Central Index (CACI) checks.

Finding: The agency/facility is not fully compliant with the standard.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☒ No ☐ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☒ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has completed a bit of remodeling in some areas, keeping resident safety in mind. However, hopes of installing a state-of-the-art video monitoring system have not yet been realized.

Analysis: Since this standard mainly applies to instances where there has been substantial remodeling or expansion, it does not fully apply to this facility at this time. However, interviews certainly indicate, and policy reviews verify, that safety considerations are required and expected when changes are made.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice'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? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR DJJ is responsible for conducting only administrative sexual abuse investigations. Alameda County Highway Patrol coordinates criminal investigations. The facility has verified that the police follow uniform evidence protocol. The agency and facility follow uniform evidence protocol, as well, which is the policy. The facility offers all residents who experience sexual abuse access to forensic medical examinations off site, at no financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. During the past 12 months, there have been no forensic medical exams conducted or indicated. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means, and documents these efforts. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. All 9 allegations in the past 12 months were investigated administratively, not requiring criminal investigation. The audit team reviewed these files and interviewed investigators, and the audit team found the facility in compliance with this standard, because they have applied it to the allegations they have received and to the investigations they have completed, and because they seem to understand these processes and appear ready and willing to facilitate forensic exams and law enforcement involvement when indicated. An interview with the Forensic Charge Nurse at the facility's listed hospital for forensic examinations was conducted. She indicated that services where not always available without a long wait, even on an on-call basis. The audit team requested that the PREA Coordinator explain what the plan would be under such circumstances. This is being addressed in the audit for the agency's neighboring facility, O. H. Close. Additionally, documentation was provided to show that the facility is attempting to enter an MOU with the Women's Center Youth and Family Services (WCYFS) for advocacy services.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

NAC, as well as DJJ, ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, according to interviews and documentation provided. In the past 12 months, 9 allegations or suspicions of sexual abuse or sexual harassment were received. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: documentation indicating that all allegations of sexual abuse or harassment have been investigated; interviews with the agency head designee and investigative staff; and policies, forms, and checklists relating to responding to reports and conducting investigations.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: 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? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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, NAC 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; 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Documentation that employees understand the training they have received; training curriculum; training schedules; and staff interviews.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. The level and type of training provided to volunteers and contractors is based on the services they will provide and the level of contact they will have with residents. All volunteers and contractors who will have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: documentation confirming that volunteers/contractors understand the training they have received; volunteer/contractor agreements and training; and policies relating to volunteers/contractors.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the 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 to the audit team. Many have received the information at previous placements as well. The agency maintains documentation of resident participation in PREA education sessions, and samples of resident signatures and logs were 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 as observed by the audit team during the facility tour.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: documentation of resident participation in PREA education sessions; samples of resident signatures; resident education logs; resident education policy and materials; resident handbook; posters observed during the site review; and interviews of staff and residents.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR DJJ typically does its own administrative, but not criminal, investigations. Sometimes the term "inquiry" is used to indicate a fact-finding process, but if there is sexual abuse or harassment alleged involving an alleged resident victim, CDCR policy clearly requires it be immediately investigated, even if there is also an "inquiry" being conducted. If a staff member is accused of wrongdoing, the Office of Internal Affairs (OIA) will investigate.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. Compliance with this standard was verified through interviews with administrators, and investigators. The auditor also reviewed documented allegations and investigations, training curriculum, documentation of investigative training received, and training policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Training of medical and mental health practitioners who work regularly at the facility 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 medical staff at this facility, but none conduct forensic exams. However, all have received PREA training.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. During interviews these staff, including the PREA Compliance Manager, demonstrated an understanding of the processes utilized by medical and forensic professionals. The audit team reviewed the training curriculum and the documentation of acknowledgement of training.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls 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? ☐ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 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 48 hours of their intake. PREA Standards require this to be done within 72 hours. Such assessments are conducted using an objective screening instrument. They 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, to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Interviews indicate residents are screened and the facility is reassessing regularly, when a resident is high-risk, and when new information regarding risk factors comes to their attention.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Interviews with random residents; interviews with staff who conduct screenings; interviews with PREA Coordinator and PREA Compliance Manager; review of PREA policy; and a review of random samples of completed screenings.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents 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? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in 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. The facility makes housing and program assignments for transgender or intersex residents in the facility 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. A transgender or intersex resident's own view with respect to his or her own safety is given serious consideration. Transgender and intersex residents are given the opportunity to shower separately from other residents. However, the auditor could not find verification that placement and programming assignments for each transgender or intersex resident are being reassessed at least twice each year, to review any threats to safety experienced by the resident. The Transgender Youth policy is still being developed and is in draft form.

Corrective Action: The "Draft" PREA Policy, states in Section 7 (a), "Within 48 hours of arrival at a DJJ facility, each youth shall be screened using the DJJ Form 8.138 PREA Screening Tool by their Parole Agent/Casework Specialist. Note: Each youth shall be re-assessed for risk of victimization or predatory behavior using the PREA Screening Tool whenever a new risk factor becomes known, within 48 hours of arrival at a new facility, and no less frequently than annually at youth's Annual Review. Placement for transgender or intersex youth shall be reassessed at minimum twice per year." The facility has no residents who identify as transgender at this time, so the auditor could not interview them or review their files or reassessments. It should be noted that this Standard requires compliance in practice and does not list any requirements for policies to be worded a certain way, so the facility can be understood to be in compliance, in practice, until the policies are officially updated.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Reviews of policy and policy updates; Reviews of policy implementation measures and timeframes; Reviews of training materials; interviews with youth, administrators, and staff who do screenings; and Random reviews of screenings and reassessments.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

NAC has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse and 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. Residents can report verbally, through the grievance process, or through the outside reporting option. NAC 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 shift. Residents are provided 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. NAC has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Staff are informed of these procedures through trainings, verified policy reviews, and posted notices.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. Verification of compliance with this standard was accomplished through a review of various documents, including resident handbooks and postings around the facility, as well as through private interviews with residents and staff. The internal agency reporting is to the Office of Internal Affairs; P.O. Box 3009; Sacramento CA 95812 (877-424-3577 or 916-464-3805). The outside

agency reporting is to the Office of Inspector General; 1011 Old Placerville Road, Suite 110; Sacramento CA 95827 (800-700-5952).

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond

is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR DJJ has an administrative procedure for dealing with resident grievances regarding sexual abuse, and this procedure is followed at NAC. 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. These grievances are assigned to someone at the level of Deputy Superintendent or higher, and the assigned administrator is prohibited from having a conflict of interest. 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. While residents can assist, one resident cannot file an appeal on behalf of another. 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. One allegation of sexual abuse was received through the grievance system in the past 12 months. The documentation regarding this grievance was reviewed by the auditor and seemed to be handled according to policy and consistent with this standard. The audit team also reviewed the Youth Grievance Policy and Youth Rights Handbook. Residents indicated they know about filing grievances, and notifications regarding this process was observed during the site review.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 and by providing, posting, and otherwise making accessible the mailing addresses and telephone numbers of local, State, or national victim advocacy or rape crisis organizations. Staff and administrators verify that the facility does inform residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored and of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents or legal guardians.

Interviews with staff and residents confirm a belief that outside confidential support is available and accessible. The audit team verified that advocacy services are available through the Women's Center Youth and Family Services in Stockton. The 24-hour Sexual Assault Line is 209-465-4997. The Memorandum of Understanding (MOU) with the Women's Center is in the process of being updated, although there is no interruption of the availability of services.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: draft of MOU with WCYFS; Access to Youth Files & Info by Legal Counsel & Authorized Representatives Policy; PREA Block Training; Resident Education documentation; PREA Brochure and Booklet for Youth during PREA Orientation; Youth Rights Handbook; interviews with youth; and, interviews with Superintendent Linda Bridges, PREA Coordinator Dr. Jonathan Yip, and PREA Compliance Manager Mark Miranda.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility provides methods to receive third-party reports of resident sexual abuse or sexual harassment by phone, email, in writing, and by personal contact. The agency publicly distributes

information on how to report resident sexual abuse or sexual harassment on behalf of residents on the agency website.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: agency website; postings observed during site review; and interviews with youth who have had visits; and interviews with staff who supervise visits.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation 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? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

NAC requires all staff to report immediately and according to agency policy: 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; any retaliation against residents or staff who reported such an incident; and any 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, DJJ 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 practitioners are mandated reporters and 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 will 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 will be made to the alleged victim's caseworker instead of to 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. Interviews with investigators, supervisors and administrators, as well as a review of policy and case documentation, indicate these policies are being followed. Policy reviewed includes: Staff Misconduct Complaint Policy; Youth Sexual Misconduct Complaint Policy; Reporting Suspected Child Abuse or Neglect Policy and Treatment Confidentiality Policy. Training reviewed includes: PREA Training Curriculum; PREA Refresher Training; and PREA Knowledge Review. Forms reviewed include: DJJ_8.235 Medical Report of Unusual Occurrence or Injury; DJJ_8.141 Record of PREA Education; DJJ_ 8.135 Sexual Assault Interview Guidelines; DJJ_8.132 Watch Commander PREA Notification Checklist; DJJ 8.137 PREA Informational Sheet for Volunteers and Contract Employees; and DJJ_8.130 Initial PREA Contact Guide. Interviews included the Superintendent; PREA Compliance Manager; and, Mental Health and Medical staff.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

When NAC learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. According to the Pre-Audit Questionnaire, in the past 12 months, there have not been times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse. Staff interviewed indicate that depending on the specifics of the information received about the substantial risk of harm, they would follow as many of the First Responder Protocols as might apply to the situation to keep the resident safe. However, staff and residents interviewed indicate they do not know of any times during the past year when a resident was at imminent risk of sexual abuse. Residents providing information to the audit team generally indicated a strong belief the staff will act effectively to keep them safe.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Interviews with staff and supervisors; interviews with residents; PAQ and supporting documentation; and PREA policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the external facility, or the appropriate office of the agency or facility where sexual abuse is alleged to have occurred, as soon as possible, but no later than 72 hours after receiving the allegation; and that this notification be documented. Policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, there have been no allegations that the facility received that a resident was abused while confined at another facility. Allegations received from other facilities/agencies are to be investigated in accordance with the PREA standards. In the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: PREA policy; interviews with Agency Head Designee, Superintendent, and Random Staff; and documentation of allegations made during the past 12 months.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific actions taken by the facility.

At the time of the on-site audit and Interim Report, it was evident that DJJ has a clear First Responder policy for allegations of sexual abuse, but that not all staff understood First Responder Duties. The agency policy requires that, like the PREA standard states, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report is required to

separate the alleged victim and abuser; and to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, they are to **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. If the abuse occurred within a time period that still allows for the collection of physical evidence, they are to **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. Policy requires that if the first staff responder is not a security staff member, that responder shall be required to **request** that the alleged victim not take any actions that could destroy physical evidence and notify security. Some staff and supervisors interviewed missed the difference between "requesting" the victim and "ensuring" the alleged abuser not destroy evidence. The Initial PREA Contact Guide stated, "Ensure the victim and suspect, . . . [protect evidence]" The audit team verified, during the on-site audit, through interviews as well as during the site review, that First Responders have been provided with an accurate, relatively comprehensive, tabulated, and laminated PREA pocket guide, detailing these required responses; and that an even more effective heuristic approach to the implementation of the updated policy, and related forms for documentation of the responses, were in process, according to PREA Coordinator Yip.

Corrective Action: During the CAP, the facility continued the update of the First Responder Duties through cards issued to staff, notices posted where first responders will see them, and various trainings.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: First Responder guide; First Responder memo; Training Records; Photographs of the PREA First responder guides placed at the YCC stations; emails detailing progress toward CAP goals; PREA Policies (both old and new); and interviews conducted with administrators and staff.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Coordinated Response Plan; interviews with facility administration demonstrating familiarity with the process; and PREA Policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has supplied the auditor with documentation to substantiate compliance with this standard. The ability to separate alleged abusers from alleged victims is in agency policy and is recognized in their labor union agreement.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: labor contracts, memos and notifications; interviews with administrators; and review of policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☐ Yes ☒ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☐ Yes ☒ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☐ Yes ☒ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☐ Yes ☒ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☐ Yes ☒ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☐ Yes ☒ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☐ Yes ☒ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

A review of policy and interviews indicate that 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. However, the full, required documentation of such monitoring for retaliation was not provided for audit review. The agency states, "DJJ HQ and NAC cannot confirm or locate any documentation relevant to this standard to indicate that there was compliance with this standard."

Corrective Action: As a review of progress made toward corrective actions, on August 31, 2018 the auditor requested that the agency "provide me with examples of retaliation monitoring, reporting to residents, and Incident Reviews . . ." Although the agency made progress toward more fully implementing their draft policies, updating their forms, and training, they provided no additional documentation to show compliance with retaliation monitoring during the CAP. The new PCM has received training on this standard.

Analysis: By a triangulation of evidence, the auditor cannot determine compliance, because of the lack of verified practice.

Finding: While the agency/facility has shown substantial attempts at compliance, it cannot be said that the facility complies in all material ways with the standard, because of the ongoing absence of verification of operationalizing the policy in practice. Therefore, the facility is not yet compliant.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort, if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. Although this is covered in policy, interviews strongly indicate isolation is very unlikely to occur at NAC, since the residents have single-occupancy rooms, and there are other effective tools available to protect residents and manage problems. In the past 12 months, no residents who have alleged sexual abuse have been placed in isolation or segregated for their protection, according to information provided.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Interviews with residents who have been isolated (for reasons that did not include their protection against sexual abuse); interviews with the Superintendent, Medical Staff, Mental Health Staff, and staff who supervise youth in isolation; and a review of relevant policies as previously listed.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) 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? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The N. A. Chaderjian Youth Correctional Facility has demonstrated that it follows DJJ policy related to criminal and administrative agency investigations. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. The substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is a resident or is employed by the agency, plus five years. Administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse, and the investigations are documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. When the quality of evidence appears to support criminal prosecution, the agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Investigators state that the credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. The departure of the alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation. No resident who alleges sexual abuse will have to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. When outside agencies investigate sexual abuse, the facility cooperates with the investigation, and it endeavors to remain informed about the progress of the investigation.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: A review of all investigations completed in the past 12 months; a review of PREA Policy; a review of Investigator Training and Training Verification; and interviews with investigator, the PREA Coordinator, and PREA Compliance Manager.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

NAC 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This standard is clearly stated in established policy and verified by the auditor during interviews, and through a review of all investigations conducted in the past 12 months,

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☐ Yes ☒ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☐ Yes ☒ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The agency also has a policy that all notifications to residents described under this standard are documented. However, at the time the Interim Report was written, the auditor had not received documentation to verify that residents have been notified as required.

Corrective Action: During the CAP, the auditor was notified that the documentation could not be located. The agency stated, "DJJ HQ and NAC cannot confirm or locate any documentation relevant to this standard to indicate that there was compliance with this standard." The facility did not go back and attempt to notify any residents, and the facility did not provide notifications regarding any investigations completed since that time. They did not provide documentation of attempts, or documentation of whether the Investigator and PREA Coordinator remembered making the notifications. The agency did provide verification that the form to be used to make notifications has been updated, and that current administrators have been recently trained regarding its usage.

Analysis: The agency acknowledges having no documentation to show compliance. They have not provided even one example of compliance with this standard regarding any of their residents who have been alleged victims in the past 18 months.

Finding: The agency/facility has not shown compliance with this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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? ☒ Yes ☐ No

115.376 (d)

- Are 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, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are 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, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. 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, although this has not been applicable in the past 12 months.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. A review of applicable policy, a review of investigations, and interviews conducted, indicate compliance with this standard. Policies particularly pertinent to this standard within PREA and HR policies are the Sexual Harassment Prevention Policy and Backgrounds Investigations Policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to the written policy provided for the audit team to review, and according to interviews conducted, the facility 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. According to the Pre-Audit Questionnaire, in the past 12

months, there have been no allegations against contractors or volunteers, and none have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. Policy and interviews indicate the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Volunteer/Contractor Contracts and training materials; PREA Policy; and, interviews with the Superintendent, staff who work with volunteers/contractors, and Investigators.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or criminal finding, that the resident engaged in resident-on-resident sexual abuse. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, and it 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. Yet, 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 but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. Verification of compliance with this standard was based on a review of policy, review of investigations, follow up documentation regarding cases where resident-on-resident sexual abuse or harassment had been substantiated, and interviews conducted with the Superintendent and Medical and Mental Health Staff.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All residents at NAC 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, as per the facility's written policy and procedure. 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. Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, and its use 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Interviews with residents who disclosed risk factors for being sexually abused/harassed; screenings and examples of follow-up care; and interviews with staff who perform risk screening.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services 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? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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.

Analysis: Verification of compliance with this standard was based on a review of policies, interviews medical and mental health staff, interviews with residents, and a review of investigative medical documentation.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does 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? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services 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? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR DJJ policies are very clear that N. A. Chaderjian Youth Correctional Facility offers medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The evaluation and treatment of such victims includes, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility provides such victims with medical and mental health services consistent with the community level of care, or better. Since NAC is an all-male facility, subsections of this standard

addressing female residents do not apply. 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 it offers treatment when deemed appropriate by mental health practitioners.

Analysis: Compliance with this standard was verified through a review of policies, investigations, medical documentation, and through interviews with staff and residents.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to policy, CDCR DJJ conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. The sexual abuse incident review team is to include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team is required to consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; and is to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; is to examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; is to assess the adequacy of staffing levels in that area during different shifts; is to assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and is to prepare 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.

Corrective Action: At the time of the Interim Report, Incident Reviews had not been provided for the auditor to review. During the CAP, a review was completed and provided to the auditor to show practice.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: PREA policy, Incident Review, and interviews with Incident Review Team members.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, 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? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

PREA Compliance Manager Mark Miranda verifies that N. A. Chaderjian Youth Correctional Facility compiles accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions, and provides this to the agency 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.

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Investigations; Incident Reviews; Survey of Sexual Violence and other data collection documentation; and related policy.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 reviews 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 can be located at: https://cdcr.ca.gov/Juvenile_Justice/PREA/docs/PREA-Annual-Report-2016.pdf

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Annual Report, Incident Reviews, and the content of interviews and documents provided by the PREA team.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CDCR DJJ ensures that incident-based and aggregate data are securely retained and requires that aggregated sexual abuse data is made available to the public annually after identifiers have been removed. The agency maintains this data for at least 10 years. Information for the previous year was reviewed by the audit team. The 2016 Annual Report is available at: https://www.cdcr.ca.gov/Juvenile_Justice/PREA/docs/PREA-Annual-Report-2016.pdf

Analysis: By a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided as follows: Annual Report, content of interviews and documents provided by the PREA team; and review of website.

Finding: The agency/facility has shown substantial compliance or complies in all material ways with the standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited? ☐ Yes ☒ No

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☐ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

During the three-year period starting on August 20, 2013, the agency did not have 1/3 of its facilities audited each year as required by the PREA Standards. The agency caught up during the second 3-year audit cycle. Audit reports can be viewed here: https://cdcr.ca.gov/Juvenile_Justice/PREA/Reports-Audits.html

Analysis and Finding: Interviews conducted, and documentation reviewed, indicate the facility has shown compliance with this standard.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued

in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Previous reports can be located at: https://cdcr.ca.gov/Juvenile_Justice/PREA/Reports-Audits.html

Analysis and Finding: Interviews conducted, and documentation reviewed, indicate the facility has shown compliance with this standard.

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document

into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir 01-02-2019

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.