

PREA AUDIT REPORT INTERIM FINAL

JUVENILE FACILITIES

Date of report: August 19, 2017

Auditor Information			
Auditor name: Susan Heck			
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Email: susanheckva@gmail.com			
Telephone number: 757-784-1675			
Date of facility visit: August 2-4, 2017			
Facility Information			
Facility name: Chesapeake Juvenile Services			
Facility physical address: 420 Albemarle Drive, Chesapeake, VA 23322			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 757-382-8748			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input checked="" type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Elizabeth Blount, Superintendent			
Number of staff assigned to the facility in the last 12 months: 147			
Designed facility capacity: 100			
Current population of facility: 61			
Facility security levels/inmate custody levels: Medium, Resident Custody Levels, 1, 2, 3 & 4 Behavioral Level System			
Age range of the population: 10-19			
Name of PREA Compliance Manager: Almondo Waters		Title: CJS PREA Coordinator	
Email address: awaters@cityofchesapeake.net		Telephone number: 77-382-8748	
Agency Information			
Name of agency: Chesapeake Juvenile Services			
Governing authority or parent agency: <i>(if applicable)</i> City of Chesapeake Human Services Department			
Physical address: 420 Albemarle Drive, Chesapeake, VA 23322			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 757-382-8748			
Agency Chief Executive Officer			
Name: Click here to enter text.		Title: Click here to enter text.	
Email address: Click here to enter text.		Telephone number: Click here to enter text.	
Agency-Wide PREA Coordinator			
Name: same as Facility/		Title: Click here to enter text.	
Email address: Click here to enter text.		Telephone number: Click here to enter text.	

AUDIT FINDINGS

NARRATIVE

Chesapeake Juvenile Services (CJS) is a medium security regional juvenile detention facility for males and females from 10-19. The facility is primarily cinderblock with a brick facing, built in 1961 and renovated in 1995. It has a 100-bed capacity and serves the cities of Chesapeake, Suffolk, and Portsmouth, and the counties of Isle of Wight and Southampton. The facility, located in Chesapeake, Virginia, is a division of the Department of Human Services of the City of Chesapeake. The average length of stay at the facility is 31 days; programming includes educational services, medical services, mental health services, individual counseling, group counseling, mentorship, recreational activities and behavior management.

There are four programs housed in Chesapeake Juvenile Services; programs include Pre-Disposition; Post-Disposition (for youth who are serving a longer detention time for more intensive services); Community Placement Program (for committed youth to serve commitments to the Virginia Department of Juvenile Justice closer to home) and a Re-entry Program (a "step-down" program for youth returning to the community from the state juvenile correctional centers). The mission of the facility is "to provide quality detention services in a safe and secure environment to the youth detained at the facility to assist them in developing positive and productive behaviors, value themselves, their families and their communities". The facility assists residents in learning to make appropriate decisions, increasing the likelihood of their future success.

CJS contracted with this auditor to conduct a PREA audit which began on August 2, 2017. A meeting was held with Kenneth Gallop, Team Leader; and Almondo Waters, PREA Coordinator/PREA Compliance Manager. They provided a population report (the facility's population on the first day of the audit was 63) and a shift roster.

There are 135 staff employed at the facility who have contact with residents; this number includes Team Leadership staff, administration, kitchen staff, and control room staff. Twenty secure staff (counselors) with direct supervision responsibilities were on duty over the course of three shifts on the first day of the audit. (The same shift was also on duty the second day of the audit.) Of the twenty staff, fifteen took part in the interview part of the audit; staff from all units and all shifts were interviewed, chosen randomly from the staff roster. In addition to the random staff interviews, seventeen specialized staff interviews were conducted over the three days of the audit. The training records and background check information of all staff interviewed were reviewed. Some staff took part in more than one interview since staff often perform more than one "PREA" role. This facility does have dedicated intake staff; these staff members also conduct risk assessments and took part in both interviews. Both day and night shift intake staff were interviewed. A total of 32 distinct staff interviews were conducted during the audit, covering all shifts and all housing units.

There are seven housing units at the facility. There is one female unit, one unit for community placement residents (residents serving commitments to the state in their home community), one re-entry unit (for residents who are returning from state commitment to spend the last part of their commitment back in their home community), and four other units for male residents. There are no segregated units for lesbian, gay, bisexual, transgender or intersex residents. Of the 63 residents in population at the time of the audit, fifteen residents were interviewed, including one resident who disclosed prior sexual abuse. No LGBTI residents were in population at the time of the audit. At least one resident from each housing unit was interviewed, with names chosen randomly from the population report. The files of all residents who were interviewed were reviewed for PREA education, vulnerability assessments and for follow-up meetings with mental health or medical staff for residents who disclosed prior victimization or having been a prior perpetrator. One resident's file was missing the signed form indicating receipt of PREA education and one file did not have a follow-up meeting within the 14 days required by the standard; all had received required vulnerability assessments.

In addition to reviewing the files of all residents interviewed during the time of the audit, this auditor did a random file review of residents admitted to the facility over the past year. The facility uses an electronic case management system. A query selecting the names of all residents who reported prior sexual abuse or who reported having perpetrated sexual abuse resulted in the names of twelve residents who fit these criteria and were also in the facility for fourteen days or more. The files of these residents were reviewed for PREA education, vulnerability assessments and for receiving follow-up meetings with mental health/medical staff within 14 days. Of the twelve, all received PREA education in the appropriate timeframe, all had vulnerability assessments within timeframe required by standard and all but one had gotten the required follow-up meeting.

The facility has nursing coverage at the facility seven days a week. Nursing staff had received specialized training in addition to PREA education given to all staff. In the event of a sexual assault, residents are transported to Chesapeake General Hospital or to Children's Hospital of The King's Daughters, both of which have SANE staff on call 24/7. No forensic exams or body cavity searches are performed at the facility.

An MOU is in place with Chesapeake Integrated Behavioral Healthcare (CIBH) to provide mental health services and support onsite at the facility. An interview was conducted with the mental health provider who is clearly an integral part of the team at this facility. The mental health provider had taken the specialized training in addition to PREA training given to all staff. This organization provides services to the whole community so is representative of the community level of care. An MOU is in place and was reviewed by this auditor.

Facility policy requires that all allegations of sexual abuse are investigated; the facility has increased its number of investigators since the time of the last audit, helping ensure a timely response to any allegation of sexual abuse or sexual harassment. All four facility investigators have taken “PREA: Investigating Sexual Abuse in a Confinement Setting” and “Investigating Sexual Abuse in a Confinement Setting Advanced Investigations” through NIC. Certificates of completion were on file and reviewed by this auditor. Two of the four investigators were interviewed during the audit and demonstrated knowledge and understanding of the training they received. The facility investigators will handle administrative and sexual harassment investigations; any allegation which appears to be criminal in nature is referred to Chesapeake Police Department (CPD). The facility has an MOU with CPD which was reviewed by this auditor which details each parties’ responsibilities in an investigation. This information is available on the facility’s website in addition to the facility’s policy to ensure an investigation of any allegation of sexual abuse or sexual harassment. Victim services are available 24/7 through the YWCA, and there is an MOU with CIBH to provide ongoing support services and another outlet for residents to make a report to an outside agency.

Victim advocate services are available 24/7 through the YWCA for support during forensic exam and through the investigative process. A supervisor at YWCA was interviewed and confirmed the agency’s role in this area. This information is provided to residents through posters, brochures and is in the “CJS Residents’ Guide to Sexual Misconduct”. Information on how to make a third-party report is provided on the website and is also in a letter sent to parents/guardians.

The facility has had one allegation of sexual abuse in the past year. The facility conducted an administrative investigation which resulted in a finding of unfounded. The resident was offered victim advocate services which he refused. The facility filled out a Sexual Abuse Report and conducted a sexual incident review even though the allegation was unfounded. The resident did receive a forensic exam at Chesapeake General Hospital; this exam was conducted by a SAFE/SANE qualified doctor. The resident was not isolated at any time.

Required PREA notices were evident throughout the facility. Other PREA posters were also in evidence, both in English and in Spanish. In addition, the facility has done an excellent job putting information on bulletin boards in the units. Information on the bulletin boards includes YWCA brochures, “Break the Silence” brochures, and telephone numbers for sexual assault hotlines. There is also a staff bulletin board; this auditor suggested including information about making reports on this bulletin board.

All residents interviewed knew about the Zero Tolerance Policy, that they had the right to be free from sexual abuse and sexual harassment, how to report and that they could not be retaliated against for reporting. Most of the residents were aware that there were support services available to them in the community; they were not as sure about the nature or scope of the services or exactly what was available. Residents were also not as clear about whether information was private or told to someone else. Residents did understand the term “mandated reporter” and its implications.

Staffing ratios meet and exceed the standard (which has an implementation date of 2017). Staffing plans add additional staff based on the population; extra staff are called in when the population includes residents who have negative relationships with each other in the community, if the composition of residents in population call for extra attention or supervision, or if special programs require additional staff. Facility policy requires documenting any non-compliance with the facility’s staffing plan. The facility provided its staffing plan review which met the requirements of the standard. The superintendent stated that a review of staffing is done at every Leadership Team meeting.

Unannounced rounds are conducted once a week on all shifts by supervisors on the facility’s Leadership Team. There are four Operations Coordinators and each takes one week per month with the facility’s Team Leader (administrative staff) taking the fifth week in the month. Rounds are documented in a logbook which was reviewed by this auditor. The facility used to do unannounced rounds twice per shift, per day, but has modified this schedule.

Education of residents is provided through the City of Chesapeake and is provided on site. School was not in session at the time of the audit so no teachers were interviewed. The facility has an active volunteer group providing services (primarily religious in nature) to residents. One volunteer was interviewed and stated that he had received PREA education and knew how and to whom he should report any suspicion or allegation. All contractors and volunteers receive information on the facility’s Zero-Tolerance policy and how to detect, prevent and respond to sexual abuse and sexual harassment along with additional PREA education commensurate with the services they provide; all have required background checks.

All residents shower separately and sleep in single occupancy rooms. Residents are allowed to bathe, shower, and use the toilet without being viewed by the opposite gender. Since the last audit, the facility added shower curtains to the shower stalls in most of the housing units to ensure that residents have privacy while bathing (some showers are directly across from resident sleeping rooms). The shower curtains are clear at the very top and the very bottom to ensure adequate supervision while still allowing privacy. This auditor reviewed camera monitors in the control room to ensure camera placement did not compromise privacy of residents.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility was toured by this auditor on August 2, 2017; the tour was provided by Mr. Gallop and Mr. Waters; Ms. Blount joined at the middle of the tour. The facility is primarily cinderblock with a brick facing, built in 1961 and renovated in 1995. There are two entrances to the facility; one entrance is for the Administrative Offices and one entrance is into the secure detention area which houses residents and resident services.

The secure entrance to the Administrative area opens into a receptionist area with the administrative offices of the superintendent and the assistant superintendent, along with a conference room, and a copy room to the left of the reception area. A hallway to the right of the reception area leads to additional offices and file rooms. A secure door opens into a hallway leading to the resident's dining room/kitchen area. Another door on this hallway is an entrance to the facility's resident library and offices used for both storage and school personnel.

There are cameras in the dining room on each side, each with a cross room view. Mr. Gallop pointed out that smaller, more vulnerable youth are seated under the camera on one side and the female residents are seated under the camera on the other side. The kitchen area is not accessible to residents; they form a line and get their trays through an aluminum shade that secures the kitchen when meals are not being served. There were six PREA posters, one YWCA poster and the Notice of Intent to Audit in the dining room.

The door from the kitchen leads into the main part of the detention facility; the kitchen door opens into a large, long hallway with the kitchen door at one end and the control room at the other end. This central hall has windows and is well lit. PREA posters are up and down the hallway. Housing units lead off this main hall along with a teacher work room/training room, the gym, and the Leadership office all having entrances into the hall. The staff bulletin board is just to the right of the kitchen door and contains information for employees; this auditor suggested posting information on how staff can privately report in this area.

Unit Two is to the right off the main hall just after entering the hallway from the kitchen. This unit houses female residents and a sign outside the door to the unit prompts male staff to announce their presence when entering the housing unit. The unit consists of a tv room, staff office, sleeping rooms, resident showers/bathrooms and a large classroom area. The area has excellent camera coverage, enhanced with the use of a convex mirror. PREA posters in English and Spanish were in evidence in this area and the classroom along with the Notice for Audit. The bulletin board held additional information such as brochures for the YWCA and "How to Report Sexual Abuse" and grievance forms. Residents ask to use the phone in the staff office to make calls. There is a phone in the classroom but it only makes collect calls to approved numbers. Residents shower one at a time; showers had shower curtains with a clear area at the top and bottom. Residents are able to shower, use the toilet, and dress without being viewed by anyone. Cameras are at each end of the hall with the sleeping rooms.

A training room is on the left after exiting the kitchen. It has one wall with windows along the hallway. This room is used for staff training. This auditor suggested keeping the blinds open. The room has a phone which can be used by residents (under supervision) to make reporting calls.

The gym also opens off the main hallway on the left. There are cameras covering the gym in opposite corners. Mr. Gallop pointed out where staff sit while supervising residents, one on each side of the gym close to bathroom doors which are monitored closely. Only one resident at a time is allowed in the bathroom. There were several storage doors off the gym for equipment, etc., and all were secured.

Entrances to additional housing units are at the approximate mid-point down the main hallway. To the right is the entrance to Unit 3 (Post-Dispositional Program), Unit 4 and Unit 5 (Community Placement Program and Re-Entry Program). A sign outside the door to the unit prompts staff to announce their presence if they are of the opposite gender. These units house males and each consists of a tv room, staff office, sleeping rooms and shower area. The area has good camera coverage. Most shower areas provided privacy---all residents shower one at a time. These units had shower areas with two shower stalls with shower curtains. They only use one of the stalls. In Unit 5, one shower stall is visible to the resident in the sleeping room across the hall; the facility has installed shower curtains to rectify this design problem. PREA posters in English and Spanish were in evidence along with the Notice for Audit. The bulletin board held additional information such as brochures for the YWCA and "How to Report Sexual Abuse" and grievance forms. Unit 5 also had a large "group" room used for counseling and other activities. There is a hallway outside Unit 5 with a supervisor's and a teacher's office. Both offices have windows and windows in the doors; one office's door and window was completely covered. This auditor suggested removing coverings to improve line of sight. There was good camera coverage in these areas. This auditor asked residents if they ever went into the staff office; all answered that they could not pass the red line. (This same question was asked in several units with uniform response. The staff offices have storage areas in them, but residents uniformly report they do not enter staff offices.)

To the left of the main hallway at the mid-point is the hall to Units 6, 7 and 8 which open on opposite sides of the hall. The hallway to the entrances to the housing units have offices on each side, each with windows and a door with glass in the door. Some of the offices had coverings over the windows and over the windows in the doors. This auditor suggested removing the coverings on the windows and doors to improve lines of sight and visual supervision to protect staff and residents alike.

Signs outside the doors to Housing Units 6, 7 and 8 prompt staff to announce their presence if they are of the opposite gender. These units

have a very similar design; upon going through the secure door there is a small office on the right (or left) and the staff office (with windows along one side) and a large open area with sleeping rooms along the sides with two showers. There are windows along the ceiling providing natural light. There are cameras at ceiling height on opposite sides of the room. The showers are behind secure doors; residents shower one at a time and are secured in the shower; they come out dressed. There are also two rooms off to the side that were designed with cameras in them to provide more intensive supervision for any residents requiring this level of observation. The monitor in the staff office was reviewed and the toilet area was not visible to the camera. Residents use the phone from the staff office. There is also a large tv room that is part of the overall unit and it has good camera coverage. PREA posters in English and Spanish were in evidence along with the Notice for Audit. The bulletin board held additional information such as brochures for the YWCA, "How to Report Sexual Abuse" and grievance forms. Housing Units 6, 7 and 8 are set up in the same way with the same sleeping room/shower/tv room/staff office setup and again, there was good camera coverage and PREA information available to residents.

There are additional offices along the main hall for the Leadership Team. Team Leaders use this area and it has a wall with windows as well. It has a secure door.

The control room is located at the opposite end of the hall from the kitchen. Semi-opaque windows are on the half that faces the hall. This auditor reviewed the cameras from the control room and no cameras compromised the residents' ability to bathe, toilet, and change without being viewed by staff monitoring the cameras either in the unit or in the control room.

To the left of master control is the intake area which houses intake offices, and the medical area. To the right of master control is the lobby for the secure entrance to the detention facility used by staff, probation officers, family members, attorneys, etc. This entrance is also secure with camera coverage. The lobby had the Notice of Intent to Audit.

The intake unit (and sally port) is beside the control room and houses the intake staff with areas to administer vulnerability assessments and provide information to residents at intake. Residents enter the unit from the sally port and are immediately in the area with secure rooms and an intake area with computer set up for residents to take part in their vulnerability assessments. They also view the PREA DVD on this computer in the intake area.

The medical unit is housed in this area also and has a small room housing the medicine cart and nurse desk and a small examination room. The front office has camera coverage but not the examination room. Posters were evident in this area.

There are two showers for use by residents at intake. This area is also well covered with cameras which allow residents to bathe, toilet, and change without being viewed by staff. Posters were evident in this area.

Through a door at the end of the intake area is a hallway leading to a room used for video conferencing and to two staff offices used by the facility's mental health provider.

SUMMARY OF AUDIT FINDINGS

The on-site portion of the audit of Chesapeake Juvenile Services (CJS) was completed on August 4, 2017.

In total:

- Fifteen direct care counselors were interviewed
- Seventeen specialized staff were interviewed (including a volunteer)
- One staff from victim advocate program was interviewed
- Fifteen residents were interviewed (including one resident who reported prior abuse)

The files of all residents interviewed were reviewed for PREA education, vulnerability assessments and follow-up meetings in timeframes required by the standards. Files for residents admitted over the last year were reviewed for the same criteria.

All areas were accessible to the auditor and the facility provided any information requested without hesitation. Residents at this facility were very respectful and engaged with this auditor willingly.

Compliance with the PREA standards and a true commitment to keep residents in their care safe and free from sexual abuse and sexual harassment is evident at CJS. All staff engaged in the interviews readily and were well versed in their answers.

Sincere thanks to Elizabeth Blount, Superintendent; Kenneth Gallop, Team Leader; and Almondo Waters, PREA Coordinator/PREA Compliance Manager, for their help throughout the onsite audit process.

Number of standards exceeded: 2

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:
CJS PREA-Zero Tolerance of Sexual Abuse and Sexual Harassment, pg. 1
Reviewed Organizational Chart
Interview with PREA Coordinator/Compliance Manager

Policy is thorough and covers all elements of the standard; the policy does an excellent job with its definitions. The PREA coordinator position is noted on the organizational chart; the position falls under Operations. Facility has a PREA Coordinator/Compliance Manager (both interviews were conducted with this staff member to ensure everything was covered) who states he has enough time to perform his duties. PREA Coordinator states that he meets with the leadership team regularly and has strong support from all departments and areas impacted within the facility. It is clear to this auditor that the entire Administrative Team has been very involved in working toward full compliance with all standards and is committed to keeping its residents safe from sexual abuse and sexual harassment. The facility PREA manual specifically notes that the administration of the facility will give the PREA Coordinator sufficient time to devote to his PREA responsibilities.

Facility’s efforts to prevent, detect and respond to incidents of sexual abuse and sexual harassment are very well described in the policy and include education of residents and staff, single occupancy rooms, and constant supervision of residents.

Standard 115.312 Contracting with other entities for the confinement of residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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Evidence:

This standard does not apply to this facility. It does not contract with any other agency for the confinement of its residents.

Standard 115.313 Supervision and monitoring

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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Evidence:

CJS 115.313 PREA-Supervision and Monitoring, 3, a), xiv., pg. 2

Interview with superintendent

Interview with PREA coordinator

Interview with administrative staff who conduct unannounced rounds

Review of Unannounced Rounds log

Review of documented staffing plan review

The superintendent stated that she meets regularly with her supervisors and staffing is discussed in these meetings. The interviews with the PREA Coordinator and Superintendent both indicated that close attention is given to each element of the standard, especially since this facility houses both male and female residents. Males are not allowed to supervise female units.

The facility has modified the frequency of its unannounced rounds from two times a day per shift to one time a week with all shifts covered over the course of the month. Unannounced rounds continue to be documented in a log which was reviewed by this auditor; rounds cover all shifts and are conducted at varied times through the day and night. Unannounced rounds are conducted by the four Operations Coordinators on the facility's Leadership Team; each takes one week per month with the facility's Team Leader taking the fifth week in the month.

This facility falls under the Department of Juvenile Justice's regulations which sets the staffing levels at 1:10. CJS has moved to 1:8 to meet the PREA standards ahead of the 10/1/2017 deadline.

CJS created a very thorough form, PREA Staffing/Facility Logistics Assessment, to help focus their staffing plan review discussion. The form includes all of the factors listed in the standard for consideration in developing a staffing plan. This auditor reviewed meeting minutes of the most current staffing plan review which noted discussion of blind spots/camera additions, judicial findings of inadequacy, findings from external oversight bodies, composition of resident population, and number of staff/possible new positions. The PREA Staffing/Facility Logistics Assessment form was not mentioned in meeting notes.

Standard 115.315 Limits to cross-gender viewing and searches

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.315 PREA-Limits to Cross-Gender Viewing and Searches, 1. Purpose.

Interviews with secure staff

Interviews with residents

Interview with medical staff

Review of training rosters

Resident and staff interviews confirm the facility's policy that cross gender pat searches are not done at this facility. (Residents and staff noted that after intake, no pat down searches are done at all.) All resident and staff interviews confirmed the facility's policy that residents may bathe, toilet, and change clothing without being viewed by staff of opposite gender. All staff interviewed indicated they have been trained on cross-gender pat-down searches.

During facility tour, this auditor noted that the facility had implemented a more permanent remedy for a problem identified in the last audit (shower areas were visible to certain resident rooms throughout the facility). The facility installed shower curtains (clear at the very top and at the bottom) to correct for design flaw.

All staff and resident interviews confirm that staff of the opposite gender announce their presence when entering housing units of opposite gender; there are laminated signs reminding staff to do this posted at the entrance of every housing unit.

There have been no cross-gender body cavity searches performed by medical or anyone else at this facility. Medical staff stated that if a body cavity search were indicated, the resident would be transported to the hospital for this procedure.

There were no transgender or intersex residents in population at the time of the audit. The facility used the Cross-Gender Search training available on the PRC to train all staff and provided training rosters to document staff participation. This training has been incorporated into the facility's annual training for staff in addition to being part of training for new hires. All staff knew that a search of a transgender or intersex resident to determine the resident's genital status was prohibited.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.315 PREA-Resident with Disabilities and Residents who are Limited English Proficient,

Interviews with residents

Interviews with secure staff

Review of resident brochure in Spanish

Posters and brochures are available in Spanish (the language represented most often other than English) and posted throughout the facility. Residents and staff all report that the facility does not use residents to interpret. The interview with the facility's superintendent confirmed that services are available for residents who are not English speaking.

Standard 115.317 Hiring and promotion decisions

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.315 PREA-Hiring and Promotion Decisions, 3, a, i-iii, pp. 1-2

Review of HR policy

Interview with HR administrative staff at facility

Review of facility personnel files (reviewed files of all staff interviewed during on-site audit)

The facility's policy is consistent with all elements of the standard. All required background checks are conducted. The City of Chesapeake has hiring practices and procedures in place for all city departments/agencies which require background checks consistent with PREA standards. The hiring manager at CJS has gotten additional PREA related questions, indicated in (a) of the standard, added to the interview and promotion process and to the annual review of employees; these questions are on a form that is included in the application/interview process for new employees and as part of annual review of employees (this part is a new practice for the facility).

This facility's mental health service providers are part of another agency within the city; files were reviewed by this auditor and background checks are in compliance with PREA standards.

All files reviewed (this auditor reviewed files of all staff who took part in an interview) had required background checks along with an annual refresher background check. Agency conducts background checks annually-exceeds the standard. Files of new hires were reviewed as part of staff interview process.

Questions about substantiated allegations of sexual abuse or sexual harassment involving a former employee are forwarded to the City's HR department.

Standard 115.318 Upgrades to facilities and technologies

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

Interview with PREA coordinator

Interview with superintendent

Review of control room monitors showing feeds from all cameras

PREA Audit Report

The facility has an extensive camera system with cameras covering housing and general-purpose areas throughout the facility. Control room monitors were observed by this auditor; no cameras were positioned in a way that showed residents as they bathed, showered or used the toilet, including rooms used for isolation or constant supervision of residents. Superintendent indicated that they walk through facility to identify blind spots and any area that would benefit residents by having a camera.

Standard 115.321 Evidence protocol and forensic medical examinations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.321 PREA-Evidence protocol and forensic medical examinations, pg. 1-2

Interviews with staff

Interview with PREA Coordinator

Interview with medical personnel

MOU with Chesapeake Police Department

MOU with Chesapeake Integrated Behavioral Healthcare

Email from YWCA director

MOU with Chesapeake Police Department identifies the recommended protocol as the one that will be used. All forensic exams will be conducted at Chesapeake General Hospital or Children's Hospital of The Kings Daughters. Both facilities have SANE staff available 24/7. Facility medical staff do not do forensic exams.

Victim advocate services will be provided by YWCA, which serves Chesapeake and the surrounding area as a rape crisis center. An email from the director of the YWCA confirming this was reviewed by this auditor. This agency is NOT part of a law enforcement agency. Residents may also report by calling the National Sexual Assault Hotline; information and numbers are provided to residents through brochures and posters in the facility.

In addition, residents may make a report through Chesapeake Integrated Behavioral Healthcare. An MOU is in place with this agency.

No residents who reported sexual abuse were available in current population.

The facility will only conduct initial inquiries for administrative sexual abuse investigations; refer to Chesapeake Police Department (CPD).

There have been no allegations of sexual abuse in the past 12 months.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.322 Policies to ensure Referrals of Allegations for Investigation, 1., pg 1.

MOU with Chesapeake Police Department

Interviews with facility investigators (two of four facility investigators were interviewed)

Review of Investigative file and report

Facility policy mirrors standard. The facility had one allegation of sexual abuse which was investigated by a facility investigator who had taken required specialized training. No allegations were referred to Chesapeake PD for criminal investigation. A MOU is in place with Chesapeake Police Department. Investigators identified CPD as the investigative authority for any allegation that appeared to be criminal in nature.

This auditor reviewed the investigation file. The facility utilized its Sexual Abuse Report form which included many of the elements necessary for such a write-up, including a description of all evidence used to determine finding, list of witnesses, etc. This report provides the information more in the form of a memorandum and notes to the file. The allegation was determined to be unfounded.

Standard 115.331 Employee training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.331 PREA-Employee Training, pg. 1-3

Training records of all staff interviewed were reviewed

Review of curriculum-facility uses training from PRC, The Moss Group

Interviews with secure staff (seven staff from 0700-1500 shift; five staff from 1500-2300 shifts were interviewed on day one; three staff from overnight staff who worked from 2300-0700 Wednesday into Thursday were also interviewed on Thursday morning before the end of their shifts.)

Training on Cross-Gender Searches and Searches of Transgender and Intersex Residents

Policy states that all elements from the standard are covered in employee training. All secure staff interviewed stated that they had been trained on all elements in the standard. Facility houses both male and female residents and training covered both. Training records of all staff interviewed were reviewed (including all staff taking part in specialized interviews); staff signed that they had received and understood the training. Training tools were from the PRC, developed by the Moss Group.

Staff also took part in the cross-gender search training provided through the PRC/NIC website. Rosters were provided and reviewed. All staff interviewed noted that this training had recently been repeated as part of annual in-service training.

Standard 115.332 Volunteer and contractor training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.332 PREA-Volunteer and Contractor Training, pg. 1-2

Interview with volunteer

Facility has a large number of volunteers who come in as large church/religious groups. They serve both the local jail (located close to CJS) and this facility.

Volunteers and contractors receive training about PREA and sign that they have received the training and understand the training they received. Volunteers and contractors receive additional training based on services provided and role in the facility (teachers and mental health staff are contractors and receive additional training).

Standard 115.333 Resident education

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.333 PREA-Resident Education, pg 1-2

Reviewed brochure, "Break the Silence" (also in Spanish)

Reviewed "Residents Guide to Sexual Misconduct" handbook (also in Spanish)

Reviewed intake information: poster (also in Spanish), "What You Need to Know" DVD (also in Spanish), PREA Handbook

Reviewed Resident PREA Education Form

Interviews with Intake Staff

Interviews with residents (15 of 55; at least one resident from each housing unit -roughly 27%)

Residents are trained on the date of intake on zero tolerance policy and all elements required by the standard. This process exceeds the 10 days given to provide additional information to residents. Residents sign a form (which includes a reference to information posted on bulletin boards) that they have received and understand the information; review of resident files (reviewed files of all residents interviewed) confirm practice. Resident interviews indicated thorough knowledge of the way to report and of zero tolerance policy. Residents were generally aware that there were services available in the community, and roughly two thirds of them identified the YWCA as the community service provider for support. Residents were less sure about what the services might entail.

Intake staff stated that residents are educated each time they come to the facility, whether they came from another facility or had been released for a couple of days and then come back. All residents are educated each time they come through intake at CJS.

Facility has done a good job making multiple types of educational material available to residents including posters, brochures, DVDs, and handbooks. Bulletin boards on each unit have been updated and have all excellent information about both community resources and forms to use for accessing any help needed inside the facility. Residents reported frequent groups on PREA related topics.

Standard 115.334 Specialized training: Investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.331 PREA-Specialized Training: Investigation, pg. 1-2

Reviewed certificates of completion from "PREA: Investigating Sexual Abuse in a Confinement Setting"

Reviewed certificates of completion from "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations"

Interviews with investigators

Agency has identified four staff (ensuring a more immediate response by having coverage on multiple shifts) to handle administrative sexual abuse investigations and investigations of sexual harassment. In addition to the PREA training mandated for all employees under 115.335, all four have received specialized training provided through NIC/PRC, "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations". Certificates are on file and were reviewed by this auditor. Two of the four investigators were interviewed and indicated strong knowledge of the training received.

Standard 115.335 Specialized training: Medical and mental health care

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.335 PREA-Specialized Training: Medical and Mental Health Care

Certificate of training from "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting"

Certificate of training from "PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting"

Interview with medical personnel

Interview with mental health personnel

Policy mirrors standard; states that in addition to the PREA training mandated for all employees under 115.335, medical and mental health care staff shall also receive specialized training pursuant to their roles and duties in the facility. All medical and mental health care staff received "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting" or "PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting" respectively in addition to PREA training mandated for all staff. Certificates of completion were on file and reviewed by this auditor. Interviews with medical staff and mental health staff confirmed knowledge from training.

Standard 115.341 Screening for risk of victimization and abusiveness

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.341 PREA-Obtaining information from residents

Interviews with residents

Interviews with staff who administer Vulnerability Assessment tool

Review of Vulnerability Assessment Tool

Review of resident files to document administration of assessment using objective screening tool

Interview with mental health practitioner

Facility revised its vulnerability assessment form last year to ensure inclusion of all the PREA elements. The new assessment tool entitled "PREA Screening Form, Vulnerability Assessment Instrument" has been in use for over a year. The facility also conducts an additional screening to capture information required by the Virginia Department of Juvenile Justice. Residents are given assessments at intake. Interviews with residents and interviews with staff who conduct vulnerability assessments confirm that this information is gathered at intake.

Staff who conduct the screening stated that information comes from residents, staff observation, and charges that precipitate the intake, as well as conversations with parents, probation officers, social workers and any assessments that might be part of the resident's intake information.

Interviews with the PREA Coordinator/PREA Compliance Manager and with staff who do the assessments indicate that there are appropriate controls on who has access to the information.

Standard 115.342 Use of screening information

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Evidence:

CJS 115.342 PREA-Placement of residents in housing, bed, program, education and work assignments
Interviews with staff who conduct risk screening
Interview with PREA coordinator
Interview with residents

Facility policy mirrors standard. No residents have been placed in isolation due to risk of sexual victimization. One resident has made an allegation of sexual abuse in the past year; at no time was he placed in isolation post allegation or at any time during the time the incident was being investigated.

No transgender or intersex residents in population at this time. This facility does not have a special unit for residents who are part of the LGBTI population; placement decisions for any LGBTI residents are made on a case-by-case basis and are made in consideration of security and management concerns. All residents at this facility shower separately.

An interview with the PREA Coordinator/Compliance Manager restated the facility's practice of making placement decisions for any LGBTI residents on a case-by-case basis, taking into consideration the facility's current population and any overall management concerns. The facility's nurse stated that residents who are in isolation for any reason are seen on every shift at the beginning and the end of the shift. Superintendent stated that isolation is used rarely. Staff members who perform vulnerability assessment stated that the tool is used to determine housing placement and the PREA Coordinator/PREA Compliance Manager added that the recommendation to supervise more closely may be made based on the vulnerability assessment tool.

Standard 115.351 Resident reporting

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.351 Resident Reporting
Resident brochure, "How to Report Sexual Abuse"
Reviewed "Residents' Guide to Sexual Misconduct" Handbook
Memo from YWCA
MOU with Chesapeake Department of Social Services
Tour observations, posters, bulletin boards, etc.
Resident interviews
Staff interviews
Interview with PREA coordinator

All staff interviewed said they accepted verbal reports, and documented them immediately. Staff knew they could privately report by calling CPS or the YWCA.

Residents interviewed uniformly reported that they were given a brochure at intake which included information on how to report; this auditor reviewed the brochure and it includes phone numbers and relevant reporting information. Residents reported that they could use the phone if they asked. Posters with this information were evident throughout the building and in all areas accessible to residents. Residents are also given, "Residents' Guide to Sexual Misconduct" handbook which contains reporting information.

The facility has done a good job of using bulletin boards on the units to convey information and provide tools to residents for making reports

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of sexual abuse and sexual harassment. Bulletin boards had brochures from the YWCA, "How to Report Sexual Abuse" brochures, and clear holders with forms for making reports. Posters are in evidence throughout the facility.

This auditor reviewed the MOU with the Chesapeake Department of Social Services and a memorandum from the Executive Director of the YWCA program, both of which confirm reporting relationships.

PREA Coordinator stated that residents are given tools to make reports in writing and ability to make calls to outside agencies. brochure includes phone numbers.

No residents are held for civil immigration purposes at this facility.

Standard 115.352 Exhaustion of administrative remedies

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.352 PREA-Exhaustion of Administrative Remedies
"How to Report Sexual Abuse" brochure
Resident Handbook
Resident interviews
Review of "Grievance Form"
Interviews with residents

Based on how allegations of sexual abuse and sexual harassment are handled in this facility, this standard does not apply to this facility. Facility policy instructs staff to follow the reporting and investigation process as described in PREA-Policies to Ensure Referrals of Allegations for Investigation (115.322); PREA-Criminal and Administrative Agency Investigation (15.371); PREA-Evidentiary Standard for Administrative Investigation (115.712); PREA-Reporting to Residents (115.373) for any written allegation of sexual abuse or sexual harassment that is received.

This facility has a grievance process that residents use to report unfair practices or any concerns they may have; the residents are familiar with this process and how to use the forms available to them. The facility allows residents to use the same forms to make written allegations of sexual abuse and sexual harassment, however, any written allegation of sexual abuse or sexual harassment is forwarded immediately to the Leadership Team (administration) and the PREA Coordinator for investigation outside the grievance process and procedure.

Residents are made aware of how such written allegations (or allegations of any type) are investigated and by whom (both during intake training and by notations on the written forms themselves); any allegation of sexual abuse or sexual harassment will be investigated by the facility investigators (administrative investigations) or referred to the CPD if the allegation appears to be criminal in nature.

No written allegation of sexual abuse or sexual harassment have received by this facility. Residents knew how to file a written report alleging sexual abuse and sexual harassment.

Standard 115.353 Resident access to outside confidential support services

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.353 PREA-Resident access to outside support services and legal representation
MOU with Chesapeake Integrated Behavioral Health (CIBH)
Reviewed “Resident Guide to Sexual Misconduct”
Email from YWCA
Reviewed “Break the Silence” brochure

Sexual abuse brochure gives YWCA hotline number and victim advocate number. All residents interviewed stated they have access to their attorneys and parents. Facility has MOU in place with community partner; email with support letter from YWCA.

This auditor spoke with a supervisor at the YWCA who stated that she has not gotten a call from CJS. She stated that the process at YWCA is for a hotline crisis counselor to report any call from a juvenile facility or an adult facility to the supervisor on shift and that the supervisor would forward the allegation to the facility and to the pd.

Policy states that residents are not detained solely for civil immigration purposes.

Standard 115.354 Third-party reporting

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

Review of letter sent to parents of residents detained at facility—includes reporting information
Review of facility website

The facility provides information on its website about how to report sexual abuse and sexual harassment. In addition, letters are sent to parents and guardians of residents detailing ways to report (in addition to other important information). The current letter has been revised with new staff contact information.

Standard 115.361 Staff and agency reporting duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.361 PREA-Staff and agency reporting duties
Secure Staff interviews
Medical staff interview
PREA Coordinator/PREA Compliance Manager interview
Superintendent interview

Facility policy mirrors standard. All staff interviewed knew they are mandated reporters and were to report immediately and according to facility policy. They knew of the requirement to comply with mandatory child abuse reporting laws. They knew they were to report suspicions, staff neglect that may have contributed to an incident of sexual abuse, and any retaliation against staff or residents for reporting or taking part in investigations into reports of abuse.

All staff, including medical and mental health staff, were aware of their duties to report and were aware of their obligation to tell residents they were mandated reporters. All staff were aware that allegations of sexual abuse were confidential.

The PREA Coordinator and superintendent both knew of the duty to report to DSS/court/PO/parent, as appropriate. The superintendent stated that all allegations (including third-party and anonymous reports) are reported to the facility's investigators and referred to the CPD if the allegation appears to be criminal in nature.

Standard 115.362 Agency protection duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.362 PREA-Agency protection duties
Staff interviews
Superintendent interview

Superintendent 's expectation is that staff respond to any threat of imminent sexual abuse by taking measures to protect the resident, removing the resident from the threat. Her expectation is that staff take action immediately.

All staff interviewed responded that they would act to protect the resident and that their response to any actual or threatened sexual abuse would be immediate.

Standard 115.363 Reporting to other confinement facilities

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.363-PREA Reporting to other confinement facilities
Interview with superintendent

The policy mirrors the standard. CJS has also never gotten a report from a resident that he/she was abused while at another facility and has never gotten a report from another facility that a resident was abused while at CJS.

Interview with superintendent confirmed information. She stated that an investigation would be started immediately and she would report to the other facility and to CPS/PD.

Standard 115.364 Staff first responder duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.364 PREA-Staff first responder duties
Staff interviews
Interview with staff acting as first responder

Facility policy mirrors the standard and has all elements. All staff interviewed knew the protocol for protecting a resident who alleges sexual abuse. This auditor suggested that the protocol be posted in the staff offices in the units. Protocol of secure and non-secure staff are the same, to protect the victim first, maintain supervision to protect the crime scene (including the victim). There have been no allegations of sexual abuse at the facility.

Facility's PREA Coordinator has developed a folder with clearly defined steps for each staff member who would be involved in a

coordinated response to sexual abuse. It lists the steps in this standard for the staff on the units.

There has been one allegation of sexual abuse at the facility. The first responder was a non-security staff (mental health provider). Resident stated incident happened in timeframe outside of evidence collection. Resident was offered victim advocate services which he declined. The resident was transported for forensic exam to include concerns about bowel impaction because resident had co-occurring complaint. CPD was called. Facility acted in accordance with standards and its Coordinated Response protocol. Interview with staff acting as first responder confirmed steps taken.

Standard 115.365 Coordinated response

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.365-PREA-Coordinated Response, pg. 1
Review of "Chesapeake Juvenile Services Response Team Protocol"
Interview with superintendent
Review of PREA Response Protocol folder developed for units

Facility has a clearly defined written protocol entitled "Chesapeake Juvenile Services Response Team Protocol" with steps listed for each department. The protocol is thorough and provides clear instructions to everyone who will be involved in responding to a resident who alleges sexual abuse.

Facility's PREA Coordinator has developed a folder with clearly defined steps for each staff member who would be involved in a coordinated response to sexual abuse. It lists the steps in this standard for the staff on the units and provides information for all others involved in a response to an incident of sexual abuse including medical personnel, facility investigators and transport staff.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.366-PREA Preservation of Ability to Protect Residents from Contact with Abusers
Interview with superintendent

This standard does not apply in Virginia. See The Commonwealth of Virginia CODE 40.1-57.2 Prohibition against collective bargaining.
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Standard 115.367 Agency protection against retaliation

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.367 PREA-Agency Protection against retaliation
Reviewed "Protection Against Retaliation" Form
Interview with superintendent
Interview with staff tasked with monitoring retaliation against staff or residents

Facility policy has all elements of the standard. Facility has developed excellent tool for both monitoring and to document actions to correct any retaliation, the "Protection Against Retaliation" form. Staff tasked with monitoring retaliation stated that he would monitor discipline reports, housing changes, etc., and follow the form. He stated there was no maximum on monitoring if the need was there. Superintendent stated that there might be extra supervision provided, frequent check ins with mental health staff.

Standard 115.368 Post-allegation protective custody

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.368 PREA-Post Allegation Protective Custody
Interview with medical staff
Interview with superintendent

Facility policy mirrors standard. There has been one allegation of sexual abuse. There have been no instances of isolating a resident for protection after or before sexual abuse. No isolation was used at any time before or during the investigation into the allegation of sexual abuse.

Nurse stated that nursing staff make rounds every shift, at the beginning and end of the shift, and would include any resident placed on isolation for a PREA-related reason. Superintendent stated that isolation is not used for this reason in this facility.

Standard 115.371 Criminal and administrative agency investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

Review of training certificates of facility investigators
Review of MOU with DSS/CPS
Interviews with investigators
Interview with PREA Coordinator
Interview with superintendent

Facility policy mirrors the standard.

Staff tasked with investigative duty listed steps including preservation of physical evidence (clothing, etc.) within 24 hours, pulling camera footage, conducting soft interviews with victim and witnesses. Facility staff tasked with initial inquiries into allegations have completed "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations" and demonstrated knowledge and retention of training. Both investigators interviewed stated that the departure of the alleged abuser nor victim would not provide basis for terminating investigation.

Facility refers potentially criminal allegations to CPD for investigation. Facility policy notes CPD requirement to also adhere to this element in the standard. Facility investigators stated they would offer support/assistance as requested and would provide any evidence collected. Facility would stay in touch with CPD to stay informed on the progress of the investigation.

There has been one allegation of sexual abuse that was investigated administratively; no allegations of sexual abuse have been referred to CPD.

Standard 115.372 Evidentiary standard for administrative investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.372 PREA-Evidentiary Standard for Administrative investigations
Interview with facility investigators (two of four investigators interviewed)

Facility policy mirrors standard. Facility refers allegations to CPD. Staff tasked with investigations are aware of evidentiary standard for administrative investigations. This facility has had no allegations of sexual abuse; there have been no investigations.

Standard 115.373 Reporting to residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.373 PREA-reporting to residents
Interview with superintendent
Interview with investigators

Facility policy mirrors standard. There has been one allegation of abuse in the past year; the allegation resulted in an administrative investigation which was unfounded. Superintendent and staff tasked with initial inquiries are aware of their responsibility to inform residents of progress of the investigation. They are aware of their responsibility to stay informed of the progress of investigations performed by CPD to facilitate reporting to residents.

Standard 115.376 Disciplinary sanctions for staff

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.376 PREA-Disciplinary sanctions for staff

The facility's policy mirrors the standard. There have been no substantiated allegations against staff. No staff have been disciplined; there were no files to review.

Standard 115.377 Corrective action for contractors and volunteers

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.377 PREA-Action for Contractors and Volunteers

Interview with superintendent

Facility policy mirrors standard. There have been no allegations against a contractor or volunteer in the past year. Superintendent stated she would dismiss or bar a contractor or volunteer from contact with residents.

Standard 115.378 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.378 PREA-Interventions and disciplinary sanctions for residents

Interview with superintendent

Interview with mental health staff

Facility policy mirrors standard. Residents may not be disciplined for sexual contact with staff unless staff did not consent to such contact. There have been no allegations against residents for perpetrating sexual abuse and no discipline given to a resident for perpetrating sexual abuse. Sexual contact between residents is prohibited by this facility; facility does not deem it sexual abuse if it determines that the activity is not coerced.

Interview with mental health staff noted that residents would be offered therapy, counseling or other interventions to address and correct underlying reasons or motivations for the abuse. Their participation would be completely voluntary and not tied to any other component of the facility’s programming. Longer term therapy offered through community providers.

Superintendent stated that disciplinary sanctions would be in keeping with the standard and the facility policy. Residents could be charged criminally and sanctions imposed through court system.

Residents who make reports in good faith are not considered falsely reporting even if investigation does not result in a substantiated finding.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

- CJS 115.381 PREA-Medical and mental health screenings, history of sexual abuse
- Review of electronic case management (Soft Tech) system for referral system
- Interview with staff who conduct screening for risk of victimization and abusiveness
- Interview with nurse
- Interview with mental health provider
- Interview with resident who reported prior victimization

Facility policy mirrors standard. Staff who conduct vulnerability assessments use case management system to ensure referrals are made. This system allows for a quick referral system and ensuring that referrals get made. Reviewed files of residents from the past year who answered yes to being prior victims or perpetrators of sexual abuse; 12 of 12 residents received follow-up meeting. Facility has controls in place to keep information confidential and also has controls over electronic case management system. Residents in this facility under 18. Medical/mental health staff inform residents that they are mandated reporters. Residents and/or parents sign permission for treatment.

Standard 115.382 Access to emergency medical and mental health services

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

- CJS 115.382 PREA-Access to emergency medical and mental health services
- Interview with nurse
- Interview with staff

Facility policy mirrors standard. Residents are transported to Chesapeake General Hospital or CHKD for access to emergency medical care. Treatment provided at no cost to resident. Medical staff stated that nature and scope of medical services determined by her professional judgment. All staff knew to separate the victim and seek immediate medical/mental health services.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence:

CJS 115.383 PREA-Ongoing medical and mental health care for sexual abuse victims and abusers

Interview with medical staff

Interview with mental health staff

Facility policy mirrors standard. This facility's mental health providers are on contract from the Chesapeake Integrated Behavioral Healthcare; services are provided both at the facility and in the community by the same organization. Provides for excellent continuity of care for residents. Residents are screened on many elements of the standard at medical intake and provided treatment consistent with the community care level. There have been no resident-on-resident allegations at this facility. Treatment is provided without cost to resident.

Standard 115.386 Sexual abuse incident reviews

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.386 PREA-Sexual abuse incident reviews

Interview with superintendent

Interview with PREA Coordinator

Interview with incident review team members (4)

Facility policy mirrors standard, including listing all elements from the standard which are considered in any sexual abuse incident review. Facility's sexual incident review team incorporates the required staff members, and includes members from CPS and CPD as appropriate. There has been one unfounded allegation of sexual abuse at this facility. Superintendent and PREA coordinator are knowledgeable about what should happen in a review of an incident.

Standard 115.387 Data collection

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

115.387 PREA-data collection

PREA Audit Report

Facility policy mirrors standard. DOJ has not requested any data. Facility does not contract with others to house their residents.

Standard 115.388 Data review for corrective action

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

Interview with superintendent
Review of annual report
Website review

The facility provided its annual report for review and it is posted on the facility’s website. Report showcased prevention and training efforts. This is the second posted annual report. Report included information about the allegation (unfounded) the facility received. Superintendent demonstrated knowledge of information gained through data review for corrective action. Policy and report indicates that personally identifiable information would be redacted from report.

Standard 115.389 Data storage, publication, and destruction

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Evidence:

CJS 115.389 PREA-Data storage, publication, and destruction
Interview with PREA Coordinator

Facility policy mirrors standard. This facility has had one unfounded allegation of sexual abuse. Data is securely held with appropriate controls in place. Policy states that personally identifiable information is removed from sexual abuse data.

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.



August 19, 2017

Auditor Signature

Date