Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report February 25, 2021

Auditor Information

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Company Name: Susan Heck Consulting, LLC	
Mailing Address: PO Box 6032	**City, State, Zip:** Williamsburg, VA 23188
Telephone: 757-784-175	**Date of Facility Visit:** September 23-24, 2020

Agency Information

Name of Agency Chesapeake Juvenile Services		**Governing Authority or Parent Agency** *(If Applicable)* City of Chesapeake, Human Services Department	
Physical Address: 420 Albemarle Drive		**City, State, Zip:** Chesapeake, VA 23322	
Mailing Address: same		**City, State, Zip:** same	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☒ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: Click or tap here to enter text.			

Agency Chief Executive Officer

Name: Jill Baker, Director, City of Chesapeake Human Services	
Email: jbaker@cityofchesapeake.net	**Telephone:** Click or tap here to enter text.

Agency-Wide PREA Coordinator

Name: Click or tap here to enter text.	
Email: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.
PREA Coordinator Reports to:	**Number of Compliance Managers who report to the PREA Coordinator:** Click or tap here to enter text.

Facility Information

Name of Facility: Chesapeake Juvenile Services			
Physical Address: 420 Albemarle Drive		**City, State, Zip:** Chesapeake, VA 23322	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☒ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: https://www.cityofchesapeake.net/government/city-departments/departments/human-services/Chesapeake-Juvenile-Services.htm

Has the facility been accredited within the past 3 years? ☒ Yes ☐ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA
☐ NCCHC
☐ CALEA
☒ Other (please name or describe: VA Department of Juvenile Justice for Virginia Standards Compliance
☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Click or tap here to enter text.

Facility Administrator/Superintendent/Director

Name: Ed Elliott, Acting Superintendent	
Email: eelliott@cityofchesapeake.net	**Telephone:** 757-382-6780

Facility PREA Compliance Manager

Name: Kenneth Gallop	
Email: kgallop@cityofchesapeake.net	**Telephone:** 757-382-6784/8748

Facility Health Service Administrator ☐ N/A	
Name: Coy Lett, nurse at facility	
Email: clett@cityofchesapeake.net	**Telephone:** 757-382-6785/8864

Facility Characteristics

Designated Facility Capacity:	100
Current Population of Facility:	35
Average daily population for the past 12 months:	39
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	10-19
Average length of stay or time under supervision	78 days
Facility security levels/resident custody levels	Medium Security Level, Behavioral Levels 1-4
Number of residents admitted to facility during the past 12 months	343
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	280
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	218
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text.

	☒ N/A
Number of staff currently employed by the facility who may have contact with residents:	93
Number of staff hired by the facility during the past 12 months who may have contact with residents:	22
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	6
Number of volunteers who have contact with residents, currently authorized to enter the facility:	50
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	7
Number of single resident cells, rooms, or other enclosures:	90
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	0

Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Neighboring jurisdiction CPS ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	6
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☒ Local police department ☐ Local sheriff's department

	☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Neighboring jurisdiction CPS if indicated ☐ N/A

Audit Findings

Audit Narrative

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

Chesapeake Juvenile Services (CJS) contacted this auditor in the spring of 2020 to conduct a PREA audit. This facility is the only juvenile facility in this jurisdiction in Virginia and serves the cities of Chesapeake, Suffolk, and Portsmouth, and the counties of Isle of Wight and Southampton. Given the situation with the Covid-19 virus pandemic and exercising an abundance of caution to conduct the audit safely, the on-site portion of the audit took place in February, 2021. This auditor and the administrative team at the facility followed the guidance of the Commonwealth of Virginia and local transmission rates to choose a time to conduct the on-site portion of the audit safely. (The facility is aware of when it will need to conduct its next audit to be in the first year of the next PREA three-year cycle.)

The on-site portion of the audit was conducted over the course of three total days, January 21-22, and February 10, 2021. The last on-site day was added to conduct a de-brief meeting with the agency head and the facility's administrative team and finish interviews with the PREA Coordinator/PREA Compliance Manager. Chief Ed Elliot is the facility's acting superintendent and Kenneth Gallop is the facility's PREA Coordinator/PREA Compliance Manager.

CJS is located in the City of Chesapeake, Virginia and is one of the agencies within its Department of Human Services. It is a medium security regional juvenile detention facility for males and females from 10-19. As noted above, it serves the cities of Chesapeake, Suffolk, and Portsmouth, and the counties of Isle of Wight and Southampton. It has a 100-bed capacity with an average length of stay of 78 days. The average daily population for the past twelve months has been 36 residents; this decreased population reflects the decrease in population reported across the Commonwealth of Virginia's secure juvenile detention facilities.

There are currently two programming tracks at Chesapeake Juvenile Services; Pre-Disposition and Post-Disposition (youth in the Post D Program are on suspended commitment and are provided more intensive services during this six month program). There is a quarantine unit for all youth as they come into the facility to help control the spread of Covid-19. Youth stay in this special unit for 14 days before being placed in a housing unit. 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".

During the pre-audit phase of the audit the facility sent the following thirty days prior to the on-site phase of the audit: the facility's Pre-Audit Questionnaire; the facility's policies and procedures; training certificates for staff who participated in any specialty training required by the standards; copies of all Memoranda of Agreement; the PREA training outlines for staff and residents; the PREA training outline for the facility's annual training; current PREA brochures for residents (English and Spanish); the resident handbook (English and Spanish); copies of the grievance procedure and the grievance form; the form used for the facility's annual assessment of its staffing plan dated August, 2020; pictures of the Notice of Audit posted

throughout the facility (date shown on the picture); and the facility's Organizational Chart. In addition to reviewing these documents, this auditor reviewed the facility's website which included all information required by the standards. The pre-audit portion of the Auditor Compliance tool was completed using the information provided by the facility and checking the website. Communication between the auditor and the facility's PREA Coordinator/Compliance Manager, Mr. Gallop, continued during the time leading to the on-site audit. This auditor sent Mr. Gallop a memorandum with questions following the pre-audit review process which helped identify possible policy revisions and helped focus questions for the on-site portion of the audit.

The on-site portion of the audit started on January 21, 2021 at 8:30 am. Mr. Gallop provided this auditor with copies of the facility's Daily Shift Schedule for the two days of the scheduled on-site portion of the audit. Staff to be interviewed as part of the audit were randomly chosen from these Daily Shift Schedules and included staff from each active housing unit and covered all shifts. This facility has three shifts: 7am-3pm, 3pm-11pm, and 11pm-7am. (Staff on the 11pm-7am shift were interviewed at 5:30am on the second day of the on-site audit.)

There are 93 staff employed at the facility who have contact with residents; this number includes Team Leadership staff, administration, kitchen staff, and control room staff. Thirty-two secure staff (counselors) with direct supervision of residents as their primary responsibility 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 these thirty-two staff, eighteen (representing 56%) took part in the interview part of the audit; staff from all units and all shifts were interviewed, chosen randomly from the daily staff schedule.

Staff members who took part in the random staff interviews all stated that they had received training on PREA and said that the required elements of the standard had been included. They were all clear about the required response to an allegation of sexual abuse and articulated the steps they would take to protect a resident in danger of imminent sexual abuse. They all stated that the steps to protect the resident would be taken immediately. They talked about the resources available to staff and residents to make reports of sexual abuse and sexual harassment and all noted that they documented any verbal reports they received.

In addition to the eighteen random staff interviews, thirteen staff and administrative team members took part in specialty staff interviews over the three (counting the day of de-brief) days of the audit. The training records and background check information for these staff members were also reviewed. Mr. Gallop was interviewed three times based on the PREA responsibilities he has; he is the PREA Coordinator/PREA Compliance Manager (both questionnaires were used to ensure nothing was missed) and he is also the staff designated to monitor retaliation against staff and residents. One teacher was interviewed as a contractor (teachers are contracted from the City of Chesapeake Public Schools), and one volunteer (the leader of the religious group that provided services and programs at the facility pre-Covid-19 restrictions) was interviewed. Fifteen specialty staff interviews were conducted during the audit, covering all shifts and all housing units. In total, 33 interviews with staff members were conducted.

The training records (including annual training), background checks and Virginia Central Registry (CPS) checks of all staff who were interviewed was reviewed. All staff had received the required staff training for PREA and all had taken part in the annual training provided for all the staff members. Annual training includes training on cross-gender pat-down searches along with other topics. All staff had the required initial background and CPS record checks; this facility has chosen to do annual background checks to ensure compliance with doing these checks for staff who have been with them for longer than five years and all these were in place.

The current resident population report was also provided on the first day of the on-site audit. Residents to be interviewed were randomly chosen from this report and included residents from each of the active housing units. Thirteen of 35 residents were interviewed during the first two days of the audit representing 37% of the residents in population. Residents from each housing unit were chosen for interviews and included one resident who identified as LBGTI. The facility has seven housing units; six housing units are currently in use including a female unit, a quarantine unit, and four units housing males (includes residents in the Post-D program).

The files of all residents interviewed were reviewed for evidence of PREA education, vulnerable population assessments and any follow-up meetings with mental health or medical practitioners which resulted from that assessment. All files reviewed contained documentation (which is signed/initialed by residents indicating understanding), that they received information about the facility's Zero-Tolerance policy and the balance of the required PREA education as part of their initial intake process. The file review documented that the facility's PREA Intake Screening Form/Vulnerability Assessment Instrument is also administered during intake and this information was also documented by resident signature in each of the files reviewed. All files indicated that the PREA education and vulnerability assessments were done within the required timeframes. Each of the residents interviewed during the on-site portion of the audit (thirteen) stated that they had gotten PREA education during intake and that the questions to determine vulnerability were also asked during this time.

Mr. Gallop also provided a list of residents who had been admitted to the facility over the past twelve months. After this list was alphabetized and duplicate names removed (residents are often admitted several times over the space of a year), there were 211 unduplicated names. Of this number, 55 names (representing 26%) were randomly chosen for file review. All had received the required PREA education and the vulnerability assessment within the timeframes required by the standards. In addition, any resident who said they had been prior victims or perpetrators of sexual abuse had been offered a follow-up meeting with a mental health or medical provider within the 14 days required by the standard. The vulnerability assessment tool prompts the staff member who administers it to report to the social worker on staff if a resident answers yes to this part of the tool. This helps ensure that an email is sent to the social worker through the facility's software system for her to meet with residents to offer the follow-up appointments as requested by the resident.

An interview with the Program Director of the YWCA of South Hampton Roads was conducted using the Supplementary Questionnaire on Community Advocate Engagement developed by Just Detention International. She stated that the YWCA and CJS had recently finalized an MOU between their two organizations even though they have been working together on the services and support for several years. The YWCA serves as an outside reporting resource for residents (or staff) at the facility. In addition, it provides accompaniment during forensic medical exam, and during any investigatory interviews/court proceedings, as requested; provides emotional support services and crisis intervention; provides information and referrals; and also provides ongoing therapy for as long as indicated providing the resident continues to be engaged in the process. She stated that the YWCA had a strong relationship with the social worker and Mr. Gallop at CJS and that her organization was providing these resources for CJS even before the formal MOU was completed. The YWCA provides virtual therapy and had started to do this before the pandemic as a way to continue to serve the residents at CJS; the YWCA has only two counselors to provide services to the entire South Hampton Roads community. Given the distance from their office to CJS, using the hour just in transportation was not practical. The services provided by the YWCA are delivered over the phone, virtually (using a "Zoom-like" software which meets their agency's confidentially requirements), onsite at the hospital and at their facility (after Covid-19 restrictions are lifted). The YWCA hotline can take reports 24/7 and the facility is called should a report come from CJS. YWCA has recently hired a Spanish-speaking counselor and have a contract with a language line should a language other than English or Spanish be required; the contract they have with the language service has a "medical level" feature which would provide translators with a higher level of knowledge and fluency given the sensitivity of the information being translated.

The Program Director at YWCA further stated that they have never gotten a report over the hotline from CJS. They do get contacted to provide services if a resident discloses sexual abuse that happened prior to coming to CJS and have gotten two to three calls of this nature over the past year. She noted that the relationship with CJS is a strong one; the social worker at CJS refers residents to the YWCA with regularity, ensuring that residents have access to ongoing care. The YWCA ensures that residents receiving services know the limits of confidentially by having them sign forms and going over the information during the first appointment (they've worked out an arrangement with CJS to fax forms back and forth for virtual visits). If a resident talk about an incident of sexual abuse that has not been previously disclosed, the counselor at YWCA works with the resident to partner in the reporting of the incident, but would report without the resident if necessary, given their mandated reporter status.

The facility tour was conducted on January 21, the first day of the on-site audit. The tour included all areas of the facility. No area of the facility was off-limits to this auditor and included housing units, the outside area, the control room, the intake area, the medical space, the kitchen and dining areas and the gym. Detailed physical space descriptions are included in the

Facility Characteristics section of this report. The control room staff provided a description of the camera system and the views of all the cameras were reviewed by this auditor. No cameras were positioned in ways that intruded in residents' privacy during bathing, dressing or toileting including the cameras in the rooms that house any resident threatening self-harm (these rooms, two per housing unit, have cameras in the rooms).

Several issues were noted during the facility tour primarily related to window coverings. There were also some unlocked doors in the gym area that Mr. Gallop noted were usually locked. This topic was discussed during the de-brief meeting and with Mr. Gallop individually. In the post-audit phase of this audit, he developed a training session for his team leaders who do unannounced rounds to help them do a more thorough, "PREA-Focused" assessment during the post-audit phase of this audit. (The review of the unannounced rounds log did not note any irregularity; some of the issues noted in the audit tour should have been documented and corrected.)

The de-brief meeting included the agency head, the acting superintendent, the PREA Coordinator/PREA Compliance Manager and the assistant superintendent. A number of issues that impacted the facility's PREA efforts were discussed in this meeting along with strategies on how to address them moving forward. The facility has had a high leadership turnover in the last three years; they have had three superintendents including the current acting superintendent and the PREA Coordinator/PREA Compliance Manager is basically new to his position having supervised the previous person until he left and then taking over all his PREA responsibilities in the last 14 months. It is felt that this turnover has had a negative impact on the PREA work which was in the minimal compliance demonstrated in some areas of the audit. The meeting underscored the need for more attention to detail (examples include updating brochures, handbooks, bulletin boards, posting the most current information for residents, etc.). The facility is anticipating some major changes in the coming months; they will either be moving to a new building or renovating their current building, and also implementing a new program for residents. There was much discussion around making sure that PREA staffing ratios were part of the discussions relating to these changes and that they document how they plan to stay in compliance. In addition, the facility had developed a number of aids for parts of its PREA compliance which were not being used efficiently. Mr. Gallop expressed a need to spend more time to maintain the progress they have made to be in compliance with the PREA standards and to act on some of the ideas presented during the on-site audit. He was supported in this by the acting superintendent and agency head.

Two areas of significance were identified and discussed at length during the audit and specifically discussed during the de-brief. The facility had developed a form for use with new hires, promotions and during employee annual reviews entitled "Chesapeake Juvenile Detention Center Prison Rape Elimination Act (PREA) Questionnaire for Fitness to Hire, Promote or Continue Contract". This form was intended for use with new hires, employee promotions, contractors and employee annual reviews. The form listed the questions required for compliance by §115.317 that relate to engaging in sexual abuse or sexual harassment in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. This form is used for new hires and promotions, however, a decision had been made to discontinue its use during employee annual evaluations by an attorney for the city without realizing the impact on PREA compliance. This problem was identified on the first day of the audit during the interview with the HR manager for the city. These forms had been removed from personnel files for employees as part of their annual evaluations and it appeared that this happened in 2018 or 2019. This situation was brought to the attention of the head of the HR department for the City of Chesapeake and the agency head and the practice was amended immediately. The facility is currently in the time period for employee evaluations and all facility employee were asked to sign the form in the post-audit period; these forms were reviewed by this auditor.

The second area of concern was with the facility's investigations into allegations of sexual abuse or sexual harassment. The facility's policy read that the City of Chesapeake Police Department would conduct all investigations into allegations of sexual abuse and sexual harassment, including any administrative investigations. The facility had trained staff members to do investigations, but the policy stated that they would not conduct even administrative investigations. During resident interviews it was found that the facility had received one allegation of sexual harassment against a teacher. Mr. Gallop acknowledged that there had been an allegation and that it had been investigated internally by one of the staff trained to do investigations. The investigation was produced and reviewed by this auditor. It had the bare minimum to be in compliance with the standard. The facility's policy was revised during the post audit phase of the audit and before the issuance of this report. This topic was discussed in the de-brief meeting and the facility was referred to the tool auditors use to assess

investigative reports as something to use as a guide when writing future reports. This facility has had no allegations of sexual abuse and only one allegation of sexual harassment (unfounded).

The bulk of the on-site audit work was completed by the end of the day on January 22, 2021. The facility tour, all resident interviews, all random staff interviews, the review of the camera system, the majority of specialty staff interviews, the review of the resident and staff files, and the review of the Unannounced Rounds Logbook were accomplished during the first two days of the audit. This auditor was on-site for approximately 22 hours during these two days. The facility de-brief meeting, the agency head interview, the PREA Coordinator/PREA Compliance Manager interview and the review of the special training documentation was completed on February 10, 2021. This auditor was on-site for approximately 7.5 hours. The total number of hours spent on-site for this audit was approximately 30 hours.

Facility Characteristics

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

CJS is located in the City of Chesapeake, Virginia and is one of the agencies within its Department of Human Services. It is a medium security regional juvenile detention facility for males and females from 10-19. As noted above, it serves the cities of Chesapeake, Suffolk, and Portsmouth, and the counties of Isle of Wight and Southampton. It has a 100-bed capacity with an average length of stay of 78 days. The average daily population for the past twelve months has been 36 residents; this decrease in population reflects similar decreases in populations reported across the Commonwealth of Virginia's secure juvenile detention facilities.

The facility has nursing coverage at the facility seven days a week. Nursing staff 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 at the facility. The MOU was reviewed by this auditor. This organization provides services to the whole community so is representative of the community standard of care. An interview was conducted with the mental health provider on CJS staff who is clearly an integral part of the team at this facility. The mental health provider had taken the required specialized training in addition to PREA training given to all staff.

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 six 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. One of the investigators was interviewed during the audit and demonstrated knowledge and understanding of the training he received. The facility investigators handle administrative and sexual harassment investigations; any allegation which appears to be criminal in nature is referred to Chesapeake Police Department (CPD). (The facility policy has been updated to reflect this change in practice as discussed under in the Audit Narrative above.) The facility has an MOU with CPD which was reviewed by this auditor and details each of the party's responsibilities in an investigation. This information is available on the facility's website in addition to the facility's updated 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 Chesapeake Integrated Behavioral Health 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. The Program Director of the YWCA of South Hampton Roads was interviewed (discussed in Audit Narrative section of this report) 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" handout. 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 harassment in the past year. The facility conducted an administrative investigation which resulted in a finding of unfounded. The report was very minimal and this concern and the facility's response is discussed in more detail in the Audit Narrative above.

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. This auditor suggested that residents be given more information about community resources and that using one of the Saturday "PREA Groups" for this purpose might be helpful.

Staffing ratios meet and sometimes exceed the standard. 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 indicates 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. The staffing plan review and the need to document its consideration during facility upgrades was discussed during the audit de-brief meeting.

Unannounced rounds are conducted once a week on all shifts by supervisors on the facility's Leadership Team. Rounds are documented in a logbook which was reviewed by this auditor. The purpose of unannounced rounds and how to meet the intent of the standard was discussed with Mr. Gallop. He devised and implemented a training for his Leadership Team during the post-audit phase to improve the effectiveness of unannounced rounds in the facility.

Education of residents is provided through the City of Chesapeake on-site. One teacher was interviewed and stated that teachers are given training on the facility's Zero-Tolerance policies and how to report any incidences of sexual abuse or sexual harassment. The facility has an active volunteer group providing services (primarily religious in nature) to residents although these activities have been suspended during the pandemic. One volunteer (who is the leader of the group) 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. They sign forms that they have received and understand this training and all were on file and reviewed. They 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. The facility added shower curtains to the shower stalls in the housing units in the older section of the building to ensure that residents have privacy while bathing (some showers are directly across from resident sleeping rooms) after the last audit and these are still in place. 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.

The facility was toured by this auditor on January 21, 2021; the tour was provided by Mr. Gallop and included all areas of the building. 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 is covered by an outside camera. It opens into a receptionist area with the administrative offices of the superintendent and the assistant superintendents, 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 PREA posters, a 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 dining room door opens into a large, long hallway with the dining room 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 a small conference room all having entrances into the hall. The staff bulletin board is just to the right of the dining room door and contains information for employees.

There are seven housing units at the facility; six are currently in use. There is one female unit, a Post-D Unit, a unit used to quarantine residents before placement in the general population and three other unit for male residents. There are no segregated units for lesbian, gay, bisexual, transgender or intersex residents.

Unit Two is to the right off the main hall just after entering the hallway from the dining room. 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/teacher workroom is on the left after exiting the dining room. It has a secure door and has one wall with windows open to the hallway. This room is used for teachers and staff to train. 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. One of these doors which should have been locked was not secured and was found to have a broken lock. A maintenance report was placed to have the door lock fixed.

Entrances to additional housing units are at the approximate mid-point down the main hallway. To the right is the entrance to Units 4 (Post-Dispositional Program) and Unit 5 (Community Placement 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. a Residents in this facility shower one at a time. The shower areas have two shower stalls with shower curtains; one of the stalls is utilized. The facility has

taken the room directly across from the showers off-line after realizing that one of the shower stalls could be seen from that room.

PREA posters in English and Spanish were in evidence along with the Notice for Audit. The bulletin boards 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. Information in the bulletin boards was updated during the post-audit phase of this audit to ensure the most current information was available to residents.

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 which were partially covered. This auditor suggested removing coverings to improve line of sight and using this as an example for staff tasked with making unannounced rounds. There was good camera coverage in these areas.

To the left of the main hallway at the mid-point is the hall to Units 6 & 7, which open on opposite sides of the hall. This area is the newer part of the building. 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 both the housing units 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; after their showers they dress before exiting. 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. Unit 7 was 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. All bulletin boards were updated during the post-audit phase of the audit.

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 also in this area and has a small room with 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 summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded: 0

Standards Met

Number of Standards Met: 44

311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
312 Contracting with other entities for the confinement of residents
313 Supervision and monitoring
315 Limits to cross-gender viewing and searches
316 Residents with disabilities and residents who are limited English proficient
317 Hiring and promotion decisions
318 Upgrades to facilities and technology
321 Evidence protocol and forensic medical examinations
322 Policies to ensure referrals of allegations for investigations
331 Employee training
332 Volunteer and contractor training
333 Resident training
334 Specialized training: Investigations
335 Specialized training: Medical and mental health
341 Obtaining information from residents
342 Placement of residents in housing, bed, program, education, and work assignment
351 Resident reporting
352 Exhaustion of administrative remedies
353 Resident access to outside support services and legal representation
354 Third-party reporting
361 Staff and agency reporting duties
362 Agency protection duties
363 Reporting to other confinement facilities
364 Staff First Responder Duties (PREA Response Protocol)
365 Coordinated response
366 Preservation of ability to protect residents from contact with abusers
367 Agency protection against retaliation
368 Post-allegation protective custody
371 Criminal and administrative investigations
372 Evidentiary standard for administrative investigations
373 Reporting to residents
376 Disciplinary sanctions for staff
377 Corrective action for contractors and volunteers
378 Interventions and disciplinary sanctions for residents
381 Medical and mental health screenings; history of sexual abuse
382 Access to emergency medical and mental health service
383 Ongoing medical and mental health care for sexual abuse victims and abusers
386 Sexual abuse incident reviews

387 Data collection
388 Data review for corrective action
393 Audits of standards
401 Frequency and scope of audits
402 Auditor qualifications
403 Audit contents and findings

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: 0

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.311 PREA-ZERO Tolerance of Sexual Abuse and Sexual Harassment
Organizational Chart
Interview with PREA Coordinator
Interview with Superintendent
Facility tour

The facility's policy is thorough and includes a description of how it prevents, detects and responds to allegations and incidents of sexual abuse and sexual harassment. The policy includes a good definition section and clear instruction to staff that due to the resident's status of being a resident, there can be no claim of consent. The policy contains an assurance that the facility's PREA Coordinator/Compliance Manager will be given sufficient time to devote to PREA related duties.

This facility is the only juvenile detention facility in this municipality and the PREA Coordinator/PREA Compliance Manager fills both roles in the facility. Mr. Gallop indicated that after being the sole person in this coordinated role, he may need more time to do this job thoroughly. The facility has been through a high degree of turnover of leadership in the last three years, and that included having had two PREA Coordinator/Compliance Managers. Mr. Gallop supervised the previous PREA Compliance Manager and took over all the PREA duties at his departure. The facility's organizational chart designates Mr. Gallop as the PREA Coordinator/Compliance Manager and his position as Team Leader is appropriately positioned to be in compliance with the standard.

The facility's acting superintendent (the third person in the position in the last three years) was interviewed and even though he has only been at the facility for a short time, he has an excellent grasp of the importance of the facility's PREA compliance and efforts.

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

This facility does not contract with another facility/agency for the housing of its residents.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

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

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

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

115.313 (d)

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

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

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

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

115.313 (e)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.313 PREA-Supervising and Monitoring
Interview with superintendent
Interview with PREA Coordinator/Compliance Manager
Review of the staffing plan
Interview with administrative staff who conduct unannounced rounds
Review of Unannounced Rounds log
Review of video documentation of unannounced round

The facility's policy is in compliance with the PREA standard, listing all elements of the standard including what should be considered in reviewing its staffing plan. The facility has adhered to the 1:8 waking hours and 1:16 sleeping hours staffing ratio since its last audit in 2017. The facility has had no incidents of not meeting its staffing plan. The facility is rated for 100 residents; its average daily population in the last year has been 39. This lower population is consistent with lower populations in detention across the Commonwealth of Virginia.

The facility's policy states that it conducts the required staffing plan review annually and has a form which is used to guide this review. The superintendent stated that all required elements are considered at the time of the formal review and on an almost daily basis to ensure coverage that maintains the staffing ratio. He described a new process for filling call-outs that has cut the time required to completely staff each shift considerably.

The facility's documentation of its staffing plan review was minimal. The form that was developed to ensure that all elements included in the standard were considered was not provided to this auditor as part of the documentation. The PREA Compliance Manager provided meeting notes that simply stated that the staffing plan was reviewed. The meeting minutes highlighted camera placement and mentioned hiring of new staff for current vacancies.

The PREA Coordinator/Compliance Manager stated that the staffing plan was reviewed often, and that a formal review was conducted once per year. This part of the standard was discussed during the audit de-brief with the agency head and superintendent. The facility has a form that is supposed to guide the review of the annual staffing plan, but the form was not used during the past annual meeting. Both the agency head and the superintendent were well aware of the need to stay within the staffing requirements and talked about plans for new programs and possible physical plant changes that would require a thorough review both to stay in compliance and to ensure the success of new programming.

The Unannounced Rounds log was reviewed and covered all shifts. This auditor was provided with a copied video of one of the facility's unannounced rounds taken from the facility's camera system. An interview with one of the team leaders responsible for conducting unannounced rounds was conducted. He indicated that he conducts rounds and knew what should

be accomplished during the rounds.

During the facility tour conducted as part of this audit, a number of issues that should have been of notice to the staff who conduct unannounced rounds were identified and pointed out to Mr. Gallop. This concern was discussed in the de-brief meeting with the facility's leadership team. Mr. Gallop has already planned to make this a training topic for his team leaders (the staff responsible for conducting unannounced rounds) to further their understanding of this standard and demonstrate what is expected if an unannounced round is conducted well.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

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

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.315 PREA-Limits to Cross-gender viewing and searches
Interviews with secure staff
Interviews with residents (35 residents in population during audit, twelve were interviewed; 34%)

Interview with medical staff

The facility's policy contains all elements necessary to be in compliance with the standard. All staff who took part in the Random Staff Interviews noted that they had been trained in how to conduct cross-gender pat down searches and stated that this training was provided by watching a DVD (the facility uses the training through National Institute of Corrections on this topic). They all noted that the facility prohibits cross-gender searches of any type except in exigent circumstances. Most noted that they couldn't think of a situation where there would be a need for this since there are always both gender staff on duty on every shift. They and the medical staff interviewed were aware that residents were not to be searched or physically examined to determine their genital status unless as part of a broader physical exam conducted by a medical practitioner.

Staff members also noted that residents are allowed privacy during toileting, bathing and dressing. All residents interviewed (12 of 35, 34%) stated they are never naked in view of the opposite gender staff (or each other) and that they have privacy while bathing, dressing and using the toilet. The shower areas of the facility were reviewed during the tour. In the older part of the building, the facility has taken additional measures to ensure that residents have privacy during bathing. Before, a resident housed in the room right across from the shower area would be able to see into the shower area (large room with a toilet and two separate shower enclosures). This room has been taken offline in most housing units in that part of the building. In addition, a shower curtain has been hung across the entrance to the shower room which is pulled when residents are showering to make sure there is privacy.

All staff and residents interviewed stated that staff of the opposite gender announce their presence when entering the housing unit of the opposite gender. There are signs posted at the front of each housing unit to remind the staff of this practice.

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

There were no transgender or intersex residents in population at the time of the audit.

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

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

115.316 PREA- Residents with disabilities & limited English proficient residents
Review of Voiance service (provides translators for fifteen languages)
Interview with agency head
Interview with superintendent
No residents who would need accommodations were in population on the days of the audit. No interviews with residents
Interviews with secure staff
Review of "Break the Silence" brochure in Spanish
Review of "Residents' Guide to Sexual Misconduct" in Spanish

The facility's policy is in compliance with the PREA standard, and lists the disabilities which would receive accommodation. Staff members knew that residents were not to be allowed to interpret for each other. The superintendent noted that there were services available through the city to ensure each resident had access to all information related to the PREA safeguards.

Posters, brochures and the Notice of Audit were all available in Spanish (after English the most common language represented in the facility's resident population). No residents who would have needed accommodations were in population on the days of the audit, so no interviews with residents on this topic were conducted.

The agency head noted that whatever resources were needed would be put into place for a resident with disabilities who needed accommodation.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

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

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

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

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

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

115.317 (e)

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

115.317 (f)

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

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

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

115.317 (g)

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

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on

substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.317 PREA- Hiring and promotion decisions
Review of Chesapeake HR policy
Interview with city HR hiring manager for the facility
Interview with agency head
Interview with superintendent
Review of "CJS PREA Questionnaire for Fitness to Hire, Promote or Continue Contract"
Review of facility personnel files (reviewed files of all staff interviewed during on-site audit)

The facility's policy contains all elements to be in compliance with the standard. All employees and contractors receive the required background checks and also checks through CPS. Background checks are repeated annually for all employees as an extra step to ensure that these checks are conducted every five years. The City of Chesapeake's Human Resources Department handles all new hire practices for the facility along with the annual checks.

The facility uses a form entitled "Chesapeake Juvenile Detention Center Prison Rape Elimination Act (PREA) Questionnaire for Fitness to Hire, Promote or Continue Contract" to ask employees the questions referenced in 115.317 (a) (1), (2) and (3). This form is supposed to be used for new hires, for employees being considered for promotion and for employees during the employees' annual reviews. The city's attorney, not realizing the significance of this form during annual employee reviews for PREA compliance, told the Human Resources Department that it was not a form that needed to be retained in the employees' files and the use of the form for annual review purposes was discontinued for this use. After discussions with the HR Manger for the city, the form will again be used for this purpose starting immediately. All current employees signed the form before the finalization of this report and will sign it during annual reviews moving forward. This problem was discussed in detail with the agency head and the superintendent during the on-site audit de-brief. The agency and facility acted immediately to rectify this problem during the on-site audit.

The personnel files of all staff chosen for interviews during the on-site audit were reviewed. All had the background checks and CPS checks required for hiring. All who have been with the facility for one year or more had also gotten the annual background check the facility has instituted to ensure compliance with doing background checks every five years.

The HR Representative assigned to the facility stated that incidents of sexual harassment are considered in determining whether to hire or promote staff.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.318 PREA-Upgrades to facilities and technologies
Interview with PREA Coordinator
Interview with agency head
Interview with superintendent
Tour of facility

The facility's policy is consistent with the standard.

The facility has installed a new camera in an area that used to be a staff office and was converted to a small conference room sometimes used for residents to have video conferences. Given the new use, a camera was installed to help monitor residents in this area while still providing some degree of privacy for the meeting. This change was noted during the acting superintendent's interview who stated that a new camera had been installed in the facility's old training room which is now used as a conference room and sometimes for meetings with residents.

There were no meeting notes that related to this new camera's placement, but both the PREA Coordinator/PREA Compliance Manager and the acting superintendent talked about the need to document in the future. This facility is likely going to go through significant renovation and perhaps be acquiring a new building. The agency head and the acting superintendent both talked of the need for keeping residents safe from sexual abuse and sexual harassment as an important focus during this planning and implementation process and the need to document such discussions to comply with PREA standards.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

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

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

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

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

115.321 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:
115.321 PREA- Evidence protocol and forensic medical examinations
Reviewed MOU with Chesapeake Integrated Behavioral Healthcare
Interviews with staff
Interview with PREA Compliance Manager
Reviewed MOU with Chesapeake Police Department
Reviewed MOU with YWCA-victim advocate services

The facility's policy is compliant with the standard. This facility conducts administrative investigation only. Any allegation that appears to be criminal in nature would immediately be referred to the City of Chesapeake Policy Department/Special Victims Unit and to Child Protective Services. (During the interview with the agency head she noted that since her agency oversees both CPS and Chesapeake Juvenile Services she is working on an agreement with a neighboring jurisdiction's CPS to remove any hint of an investigation being compromised.)

The MOU with the CPD states that they would use a protocol appropriate for youth such as the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents". It also states that the facility would request CPD/SVU to adhere to all aspects of the standard.

Any resident victim of sexual abuse would have access to forensic medical exam at Chesapeake Regional Medical Center with SANE/SAFE staff available 24/7. All medical services would be provided free of charge.

Victim advocates would be made available either through the CPD's Special Victims' Unit or through the YWCA victim advocate program. The facility has recently signed an MOU with the YWCA which was reviewed by this auditor. This is a significant improvement over the last PREA audit when the agreement with the YWCA was a verbal one with a follow-up email.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

115.322 (b)

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

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

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.322 PREA- Policies to ensure referrals of allegations for investigations
Reviewed MOU with Chesapeake Department of Human Services
Reviewed MOU with City of Chesapeake Police Department
Reviewed website for Chesapeake Juvenile Services (Under the City of Chesapeake Department of Human Services)

Interview with agency head
Interview with facility investigators (one of five were interviewed)
Review of facility/agency website

The facility's policy meets the requirements of the standard. The website was reviewed by this auditor and contains all required elements of the standard including a description of the responsibilities of the investigative entity and that the entity is the one with the legal authority to conduct a criminal investigation.

One of six facility investigators was interviewed. The investigator stated that allegations that are criminal in nature are referred to CPD and CPS. He knew that preponderance of evidence was the standard to substantiate allegations. He stated that all allegations are investigated regardless of the status or perceived status of the alleged victim.

The facility conducted one administrative investigation over the last year. It was in response to a sexual harassment allegation and the report was very minimal. It consisted of a form that documents notifications to the state Department of Juvenile Justice (a Serious Incident Report), a facility incident report and a one paragraph summary that did not detail any questioning of witness or the alleged victim. This was discussed with the facility and the forms that PREA provides for auditors to assess investigative reports was shared with the agency head, superintendent and PREA Coordinator/PREA Compliance Manager during the audit de-brief to help the facility know the level of investigation that is expected.

Chesapeake Juvenile Services is under the umbrella of the Department of Human Services for the City of Chesapeake. This agency also oversees Child Protective Services. During the interview with the agency head she noted that since her agency oversees both CPS and Chesapeake Juvenile Services she is working on an agreement with a neighboring jurisdiction's CPS to remove any hint of an investigation being compromised.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.331. PREA-Employee Training
Training records of all staff interviewed were reviewed
Annual training rosters reviewed
Interviews with secure staff-random staff interviews (total of 18 interviews conducted of available 47 available staff on days of on-site audit were interviewed; 38%)
Reviewed training outline and curriculum

Facility's policy is in compliance with the standard, including all elements listed in the standard. Of the 47 staff members available for interviews over the two days of the on-site audit (covers four shifts including 7-3, 3-11 and 11-7 on first day and 7-3 on second day), 18 random staff interviews were conducted. This number represents 38% of the staff. At least one staff member from each housing unit and shift was chosen for interviews. Staff members who were interviewed were chosen randomly from the roster provided by the PREA Coordinator/Compliance Manager at the beginning of the onsite audit. Overnight staff (11pm-7am) were interviewed between 5:30-7:00 am on the second day of the audit.

All staff members interviewed stated that the training had included all the elements contained in the standard. They noted that the facility does not do cross-gender pat down searches; they also noted that they had received training on how to conduct such searches in a professional manner through the PRC/NIC. Training records for all staff interviewed were reviewed. Training rosters for annual training were also reviewed and staff stated that they were trained on the cross-gender pat down searches at their annual training as well. All staff knew of their duty to report and stated that they knew they could report privately. They noted that residents could report in multiple ways and that verbal reports were taken by staff and documented right away. All staff stated that they would immediately take action to protect a resident who reported a risk of imminent sexual abuse. Staff members said they announce their presence when they enter a housing unit of the opposite gender (there are signs reminding staff to do this outside every housing unit). This was confirmed during interviews with residents. Staff stated that residents were allowed privacy for bathing, dressing and using the toilet.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and

contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.332. PREA-Volunteer and Contractor Training

Interview with contractor (teacher)
Interview with volunteer (chaplain)

The facility's policy contains all elements to be in compliance with the standard. Volunteers and contractors are trained on zero-tolerance policy; how to report sexual abuse; and their roles in helping to detect, prevent and respond to sexual abuse and sexual harassment. The training they receive is based on the services they provide. The facility documents that volunteers and contractors understand the training they receive with signatures on the sign-in sheet of PREA Guidelines for Visitors and Contractors and any other training they receive

The lead volunteer from the religious group which provides programs, etc. for the facility was interviewed. He stated that the volunteers were made aware of the facility's Zero Tolerance policy and how to report. He stated that volunteers from his group are never alone with residents. The facility has had no volunteers since March, 2020 due to the COVID precautions.

The facility's teachers are provided through the City of Chesapeake Public Schools and are considered contractors. A teacher was interviewed and stated that he was aware of the facility's Zero Tolerance policy. He stated that the facility held special training for the teachers. He said that he knew what to look for and how to report.

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

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

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.333 PREA-Resident Education
Reviewed "Residents' Guide to Sexual Misconduct", Spanish version available
Reviewed "Break the Silence" brochure, Spanish version available
Interviewed Intake Staff
Interviewed residents (18 of 35 in population on the two days of the on-site audit)
Reviewed 55 of 211 unduplicated (34%) past resident files for compliance

The facility's policy contains all elements required to be in compliance with the standard. The brochure used as part of resident education was reviewed along with the "Residents' Guide to Sexual Misconduct". These materials are available in English and Spanish. Residents view a video as part of their PREA education. Both of these publications were updated during the time of the on-site audit and the final review to clarify information relating to the investigation of sexual abuse and sexual harassment.

Intake staff stated that all residents get PREA education every time they are admitted to the facility, even if they were only

gone for one or two nights. Residents sign that they have been given and understand their PREA education and this form is kept in their files. In addition, residents have PREA education on the housing units every Saturday.

All residents interviewed (18 of 35 in population; at least two residents from each active housing unit) stated that they had gotten PREA education, information about the facility's Zero Tolerance policy and how to report any incidence of sexual abuse or sexual harassment at the time of their intake.

Residents to be interviewed were chosen randomly from a population sheet provided on the first day of the on-site audit. The files of the 18 residents interviewed were reviewed and all had received PREA education at the time of their initial intake.

In addition, 55 of 211 (34%) unduplicated admissions from the past year were reviewed and all had received PREA education within the required timeframes. Files to be reviewed for PREA education and for vulnerability assessments were randomly chosen from a list of all residents who were admitted to the facility from January 1, 2020 to January 1, 2021. The list was alphabetized and duplicate admissions were subtracted (residents often are admitted multiple times to this facility). Note that if there were duplicate admissions in a resident's file, those were reviewed to ensure intake PREA education for each admission, just not counted in the 55 unduplicated files reviewed.

In addition to the Intake PREA education, there are posters throughout the facility (in English and in Spanish), brochures in bins on each unit (in English and in Spanish) and posters on the bulletin boards on the units.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

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

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

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

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

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.334 PREA-Specialized Training; Investigation
Review of NIC training (six auditors have taken this training)
Reviewed certificates of completion from "PREA: Investigating Sexual Abuse in a Confinement Setting"
Interviews with one of six facility investigators

The facility's policy includes all the elements required in the standard. The facility designates one investigator for each shift to ensure a more rapid investigative response to any incident of sexual abuse. In addition to the training required under 115.335, all six have received investigative training through NIC entitled "PREA: Investigating Sexual Abuse in a Confinement Setting". Certificates documenting this training are on file. Six investigators have also had Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations" through NIC.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA

115.335 (b)

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

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.335 PREA-Specialized Training: Medical and Mental Health Care
Review of Certificate of training from "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting"
Review of 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

The facility's policy contains all elements to be compliant with the standard. It includes the language that the specialized training provided to medical and mental health personnel is in addition to the general training provided to all employees.

Medical personnel have taken the required specialized training required by the standard. Certificates of completion for training were reviewed. Forensic exams are not conducted at the facility; residents are transported to Chesapeake Regional Medical Center. The facility's medical personnel confirmed that she had received the required specialized training and that she has a thorough understanding of the training she received. She noted that she had also had the PREA training provided to all staff and required in addition to the specialized training she received pursuant to her role in the facility.

The facility has a mental health provider on staff. She stated that she had received the specialized training required to serve in this role and that she understood the training she received. She also stated that she has had the training provided to all staff about PREA.

Certificates of training were reviewed for both of these interviewed staff members.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

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

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

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

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

Evidence:

115.341 PREA-Obtaining Information from Residents
Interviews with residents
Interview with staff who administers Vulnerability Assessment Instrument
Interview with PREA Compliance Manager/Coordinator
Review of PREA Intake Screening Form Vulnerability Assessment Instrument
Review of files of current residents who were interviewed during the onsite audit (12 of 35 residents) for administration of vulnerability screening instrument
Review of 55 of 211 files (26%) of files of past residents (from 1/1/2020 to 1/1/2021) document screening for administration of vulnerability screening instrument

The facility's policy is in compliance with the standard, and its PREA Intake Screening Form Vulnerability Assessment Instrument contains all elements required by the standard as well as being an objective screening instrument. This facility uses an additional screening instrument to capture information required by the Virginia Department of Juvenile Justice.

All the residents who were interviewed stated that they were given this assessment at intake; most residents said they had not been given the assessment again (most residents' length of stay is shorter than 59 days).

This facility has an intake area/unit and have designated staff who perform intake and vulnerability screening. The intake staff member interviewed on the first day of the onsite audit stated that the assessments are done during intake or by the late morning of the next day (if the resident comes in during the night) and before the resident is assigned to a housing unit. She stated that she uses information that comes in with the resident, the information provided by the resident's charge, the vulnerability assessment instrument and asks the resident directly to determine the resident's risk of sexual victimization. She stated that the information is kept confidential and on a "need to know" basis. A reminder to keep the information private is on the form. She stated that information from the assessment is used to make housing decisions; housing options are more limited during this time due to having a unit for new residents to isolate for 14 days to determine if they are positive for the COVID virus.

The PREA Coordinator/Compliance Manager also stated that the facility has controls in place to keep sensitive information private and that it is secured.

Standard 115.342: Use of screening information

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

115.342 (a)

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

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

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

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

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (c)

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

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

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

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

115.342 (d)

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

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

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.342 PREA-Placement of residents in Housing, Program, Education, and Work Assignments
Interview with Superintendent
Interview with staff who conduct risk screening
Interview with PREA coordinator
Interview with resident who identifies as gay
No residents who are intersex or transgender are in population at the time of the onsite audit.

The facility's policy is in compliance with the elements of the standard. Residents are placed in housing units using all information gathered at the time of intake and by using the information from the vulnerability assessment instrument.

This facility does not have a separate isolation unit. No residents have been in isolation for risk of sexual victimization in the last 12 months. There are two rooms on each of the housing units that are used to house residents who are displaying self-harming behaviors (these rooms have cameras to facilitate observation) and are occasionally used for "room time" for behavior. Isolation is not used to house residents who are gay, transgender, intersex. The superintendent stated that residents would not be isolated as a safe keeping measure and expressed his belief that any isolation is not in a resident's best interest. The PREA coordinator/compliance manager stated that residents were not isolated for risk of sexual victimization and there is no special unit for residents who identify as LBGTI.

The intake staff stated that a transgender or intersex resident's own view of his/her safety would be given consideration in housing placement. She also noted that each resident's housing is discussed as part of weekly team meetings, including any resident who is transgender or intersex.

No transgender or intersex residents were in population at the time of the onsite audit. One resident who identified as gay was

interviewed and she stated she is housed in the female housing unit and not isolated.

The facility's policy states that housing decisions for LGBTI residents would be made on a case-by-case basis. Both the nurse and the mental health provided stated that if residents are placed in one of the rooms with a camera used to monitor residents who are threatening self-harm, they are visited each day and as many times as they request. All residents in this facility shower separately.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

115.351 (c)

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

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

115.351 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.351 Resident Reporting
Reviewed "If Abuse Happens to You…Break the Silence" brochure
Reviewed CJS "Residents' Guide to Sexual Misconduct"
MOU with YWCA
MOU with Chesapeake Department of Social Services
Tour observations, posters, bulletin boards, etc.
Interviews with residents
Interviews with staff
Interview with PREA Compliance Manager

The facility policy is in compliance with the standard, including all required elements.

All units have blank grievance forms that residents could use to make a written report of sexual abuse or sexual harassment. Brochures which detail how to make a report are on every unit in bins. There are posters all over the facility encouraging residents to report if anything happens to them and providing the number to call if they want to make a report outside the facility. Residents stated that they would be allowed to use the telephone if they asked to and all staff noted that residents would be given access to a telephone for reporting and as much privacy as possible to make a call.

Staff stated that residents could make reports verbally, in person, and through a third person and that verbal reports are taken and documented right away. Staff members stated they knew they could use some of the same resources available to residents

if they wanted to report outside the facility.

The MOU with Chesapeake Department of Social Services and a MOU with the YWCA program were reviewed and both confirm reporting relationships. During the interview with the agency head she stated that she is currently working to establish an agreement with a neighboring jurisdiction's CPS since her agency oversees the City of Chesapeake's Humans Services (CPS) and the Chesapeake Juvenile Services and wanted to ensure an investigation with biases.

Residents are not held for civil immigration purposes at this facility.

The PREA Compliance Manager stated that the facility provides multiple ways to report outside the facility including writing a letter or calling one of the posted numbers that connect with an outside resource. Residents will be provided with the necessary tools to make a written report.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

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

115.352 (e)

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

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

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

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

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

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.352 Exhaustion of Administrative Remedies
Resident interviews
Reviewed "If Abuse Happens to You…Break the Silence" brochure
Reviewed CJS Residents' Guide to Sexual Misconduct
Reviewed Grievance Forms
Facility Tour-grievances were available on all units and grievance policy was posted

The facility's policy is in compliance with the standard. Residents in this facility are familiar with the grievance system and how to use it. Since this is a system they know and understand, the facility allows residents to use the form to make allegations of sexual abuse and sexual harassment, however, the grievance procedure is very clear that any grievance that alleges sexual abuse or sexual harassment will not be investigated through the grievance system but will be referred immediately to a facility investigator, the CPD and to CPS (if warranted). The grievance form makes the same distinction and so do all the PREA brochures; they consistently tell residents that allegations of sexual abuse and sexual harassment are investigated by facility investigators or by the CPD and CPS. They also instruct residents to use another way to report (tell a staff, call the hotline, etc.) if the situation they are reporting is an emergency.

There have been no grievance forms used to file an allegation of sexual abuse or sexual harassment and no grievance forms use to alert the facility of an allegation of substantial risk of imminent sexual abuse during the past 12 months. There have been no instances of the agency disciplining a resident for using a grievance form to allege sexual abuse or sexual harassment.

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

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

115.353 (a)

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

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

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

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

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Evidence:

115.353 PREA-Resident Access to Outside Support Services and Legal Representation
Review of MOU with Chesapeake Integrated Behavioral Health
Reviewed "Resident Guide to Sexual Misconduct"
Review of "Break the Silence" brochure
Review of bulletin boards on units and posters in hallways of facility
Interviews with residents
Interview with Superintendent
Interview with PREA Compliance Manager
Interview with Program Director at YWCA of South Hampton Roads (Community Advocacy Agency)

The facility's policy is in compliance with the PREA standard. The policy states that residents are not held solely for immigration purposes.

The facility has agreements with CPD and with Chesapeake Integrated Behavioral Health for service provision and recently completed an MOU with YWCA to provide services. The MOU with Chesapeake Integrated Behavioral Health is from 2017 but there has been no change in circumstance that would impact the MOU.

An interview with the Program Director of the YWCA of South Hampton Roads was conducted using the Supplementary Questionnaire on Community Advocate Engagement developed by Just Detention International. She stated that the YWCA and CJS had recently finalized an MOU between their two organizations even though they have been working together on the services and support for several years. The YWCA serves as an outside reporting resource for residents (or staff) at the facility. In addition, it provides accompaniment during forensic medical exam, and during any investigatory interviews/court proceedings, as requested; provides emotional support services and crisis intervention; provides information and referrals; and also provides ongoing therapy for as long as indicated providing the resident continues to be engaged in the process. She stated that the YWCA had a strong relationship with the social worker and Mr. Gallop at CJS and that her organization was providing these resources for CJS even before the formal MOU was completed. The YWCA provides virtual therapy and had started to do this before the pandemic as a way to continue to serve the residents at CJS; the YWCA has only two counselors to provide services to the entire South Hampton Roads community. Given the distance from their office to CJS, using the hour just in transportation was not practical. The services provided by the YWCA are delivered over the phone, virtually (using a "Zoom-like" software which meets their agency's confidentially requirements), onsite at the hospital and at their facility (after Covid-19 restrictions are lifted). The YWCA hotline can take reports 24/7 and the facility is called should a report come from CJS. YWCA has recently hired a Spanish-speaking counselor and have a contract with a language line should a language other than English or Spanish be required; the contract they have with the language service has a "medical level" feature which would provide translators with a higher level of knowledge and fluency given the sensitivity of the information being translated.

The Program Director at YWCA further stated that they have never gotten a report over the hotline from CJS. They do get contacted to provide services if a resident discloses sexual abuse that happened prior to coming to CJS and have gotten two to three calls of this nature over the past year. She noted that the relationship with CJS is a strong one; the social worker at CJS refers residents to the YWCA with regularity, ensuring that residents have access to ongoing care. The YWCA ensures that residents receiving services know the limits of confidentially by having them sign forms and going over the information during the first appointment (they've worked out an arrangement with CJS to fax forms back and forth for virtual visits). If a resident talk about an incident of sexual abuse that has not been previously disclosed, the counselor at YWCA works with the resident to partner in the reporting of the incident, but would report without the resident if necessary, given their mandated reporter status.

Residents all stated that they have access to their parents and their attorneys. In person contact has been very limited since the beginning of the COVID-19 pandemic, but residents stated that the facility provides more free calls each week to help make up for the lack of in person meetings. Residents were somewhat vague about what types of services are available in the community but most knew there was something. When pressed, they stated there was probably "therapy". This auditor suggested to the superintendent and the PREA Coordinator/Compliance Manager that using one of the Saturday PREA education groups per month to talk about community resources would be of benefit to the residents. Residents seemed to understand the concept of mandatory reporting and knew of the limits of confidentiality.

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence:

115.354 PREA Third-Party Reporting
Reviewed the facility website
Reviewed letter to parents/guardians

The facility's PREA policy is in compliance with all elements of this standard.

Information on how to make reports of sexual abuse or sexual harassment is available on the facility's website. Information on how to report is also posted at the facility in pamphlets. Parents are sent a letter telling them how to make a Third-Party Report and providing telephone numbers and various agencies they can call to make a report.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

115.361 (e)

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

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

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence:

115.361 PREA-Staff and Agency Reporting Duties
Random staff interviews
Mental Health staff interview
Medical staff interview
PREA Coordinator/PREA Compliance Manager interview
Superintendent interview

The facility's policy is in compliance with the standard.

All staff interviewed (including mental health and medical staff members) stated that they were required to report any knowledge, suspicion, or information they received regarding an incident of sexual abuse or sexual harassment that may occur

and any staff action or failure to act that may have contributed to the incident. All staff said they were aware of mandatory reporting laws, that they were mandated to report, and that they would need to tell residents of their duty to report. All staff members knew that allegations of sexual abuse or sexual harassment were confidential.

The superintendent stated that all allegations would be referred for investigation, either to the facility's investigators or CPD, as appropriate, including third-party and anonymous reports. He also noted that he would need to report allegations to a resident's parent/DSS/or juvenile court as indicated.

The PREA Coordinator/Compliance Manager stated that reports would be made to CPD/CPS and to parents as long as there was nothing noting no-contact. The juvenile court and/or social services would be contacted as appropriate.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

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Evidence:

115.362 PREA-Agency Protection Duties
Staff interviews
Interview with agency head
Interview with superintendent

The policy of the facility includes all elements of the standard and is in compliance.

All staff interviewed stated that they would do whatever was necessary to ensure the safety of the resident at risk of imminent harm. They noted that they would take those actions immediately.

The superintendent stated that he would expect his staff members to take immediate steps to keep the resident safe. The agency head stated that she would expect that the staff would move to immediately protect the resident and place him/her in a protected environment and make referrals. Both the superintendent and the agency head noted that they would expect staff to act immediately.

The facility has received no reports of imminent sexual assault.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence:

115.363 PREA-Reporting to Other Confinement Facilities
Interview with superintendent
Interview with agency head

The facility's policy complies with the standard, containing all required elements.

This facility has not gotten any notifications from any other agency and has not received an allegation from a resident about another facility.

The superintendent was aware of his responsibility to notify the other facility and would make notification right away. He noted that he knew that included making notification to the agency with the legal authority to investigate such an allegation in that jurisdiction. The superintendent stated that any report received from another facility would be investigated to the fullest extent.

The agency head stated that notifications would be made right away and that referrals would be made. She further noted that since CJS is under the same agency as the city's social services/CPS unit, a neighboring jurisdiction's CPS would do an investigation on any allegation received involving CJS. This change in practice/procedure is recent as of October, 2020 and is in the process of being made more formal.

The facility states that it has not received such a report or needed to make such a notification.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth,

changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

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Evidence:

115.364 PREA-Staff First Responder Duties
Staff interviews
Instruction on units for first responders

The facility's policy mirrors the standard and specifically lists the steps the first security staff to respond should take. The policy also notes the steps for non-security first responders to take.

All staff who took part in random staff interviews indicated knowledge of the steps to take should they receive an allegation of sexual assault; most staff listed protection of alleged victim as the first step.

During the tour of the facility, this auditor asked for the chart that reminds staff of the steps to take and the staff was able to produce if after looking through several drawers. A discussion during the on-site de-brief highlighted an opportunity to enhance staff's knowledge by using the discussion of these steps as an in-service tool. The PREA Coordinator/Compliance Manager updated the PREA folder kept on each unit during the time after the on-site audit and before the final report was issued to enhance the facility's response to any allegation of sexual abuse or sexual harassment. The folders replaced the old folder and have updated brochures and handouts.

No allegations have been made at this facility in the past 12 months so there was nothing to review from past allegations.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

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Evidence:

115.365 PREA-Coordinated Response
Review of Chesapeake Juvenile Services Response Team Protocol
Interview with superintendent
Review of PREA Response Protocol folder

The facility's policy includes a document entitled, "Chesapeake Juvenile Services Response Team Protocol" which does a thorough job of describing the purpose of a coordinated response, the necessary steps and what each part of the team's response should be.

During the tour of the facility, this auditor asked for the PREA Response Protocol folder which was noted in the last audit. The staff member was able to produce if after looking through several drawers. This auditor suggests that the facility use the "CJS Response Team Protocol" and the PREA Response Protocol folder as an in-service. The superintendent noted that doing a mock response would be helpful for staff.

The PREA Coordinator/Compliance Manager has been very proactive in the days following the on-site portion of the audit. He has updated the PREA folder kept on each unit to enhance the facility's response to any allegation of sexual abuse or sexual harassment. In addition, bulletin boards have updated brochures, handouts and policies (as appropriate for residents' viewing).

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

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence:

The Commonwealth of Virginia is a non-union state.

The Commonwealth of Virginia CODE 40.1-57.2 Prohibition against collective bargaining.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

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

115.367 (b)

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

115.367 (c)

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

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

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Evidence:

115.367 PREA-Agency Protection Against Retaliation
Interview with agency head
Interview with superintendent
Interview with staff member tasked with monitoring retaliation against staff or residents

The facility's PREA policy does a very good job of defining the responsibility for monitoring for retaliation should an allegation be made and contains all elements to be in compliance with the standard. The facility also uses a tool to monitor and track its efforts to monitor retaliation should it be necessary. The form incorporates all elements required by the standard which provides further safeguards for staying in compliance.

The agency head noted that staff at CJS know there is no tolerance for retaliation. This issue is addressed in the city's HR policy and is an offense which could result in termination. The superintendent stated that this would be monitored closely for as long as necessary.

The interview with the staff member who will monitor retaliation indicates his understanding of the steps necessary to monitor retaliation. The staff member listed a number of possible signs of retaliation and how they might present themselves.

The facility's policy states that monitoring will happen for "at least 90 days".

This facility has had no allegations of sexual abuse; there was no documentation for monitoring of retaliation required or available.

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

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

The facility's policy does a good job of detailing its response to protective custody should there be a need and it is in compliance with the standard. It states that residents will not be denied daily large muscle exercise, any legally required educational programming/special education services, and will receive daily visits from medical/mental health providers. It also states that residents will have access to other programs/work opportunities to the extent possible.

No resident has been held in post-allegation protective custody in this facility so there was no documentation to review. No residents in population had made an allegation or been in protective custody.

There have been no allegations of sexual abuse in this facility; there were no records of isolation following an allegation to review.

Interviews with the facility's mental health, medical staff, and superintendent indicate understanding of responsibilities if residents are in isolation after an allegation.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

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

115.371 (b)

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

115.371 (c)

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

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

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

115.371 (d)

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

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.371 PREA-Criminal and Administrative Agency Investigation
Review of training certificates of facility investigators
Review of MOU with Chesapeake Human Services
Review of MOU with Chesapeake Police Department/Special Victims Unit
Interviews with investigator
Interview with PREA Coordinator
Interview with superintendent

The facility's policy incorporates the required elements of the standard. The policy was updated to reflect the practice of the facility; the policy originally stated that the CPD would do all investigations, administrative and criminal. At the time of the onsite audit, it was found that the facility had done an administrative investigation into a sexual harassment allegation and this was discussed with the administrative team. The policy was updated to reflect that the facility does administrative investigation.

The facility conducted one investigation into a sexual harassment allegation over the past year. The investigative report was reviewed by this auditor and found to be minimally compliant with what the standard requires. Resources have been shared with the facility to help clarify what is expected and how the facility can improve its documentation and written reports.

The facility policy continues to state that any allegation that appears to be criminal in nature or might lead to a criminal investigation is referred to the Chesapeake Police Department. The facility has an MOU with the CPD which was reviewed by this auditor and includes elements to be compliant with the standard. There is also an MOU with the Chesapeake Human Services which oversees both CJS and CPS. The agency head noted that any future allegations involving CJS will be handled by the CPS in a neighboring jurisdiction to ensure objectivity in the investigation since both CJS and the CPS unit fall under the Department of Human Services in the city.

All designated facility investigators have taken the specialty trainings for investigators through NIC and the certificates of completion were reviewed.

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.372 PREA-Evidentiary Standard for Administrative Investigations
Interview with facility investigator

The facility's policy mirrors the standard and states that the evidentiary standard is preponderance of evidence. The facility investigator interviewed knew the standard of evidence for administrative investigations is preponderance.

This facility has had no allegations of sexual abuse; there has been one investigation into sexual harassment and the standard of evidence was noted in the brief write-up.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.373 PREA-Reporting to Residents
Interview with superintendent
Interview with investigator

The facility's policy contains all elements required to be in compliance with the standard.

There have been no allegations of sexual abuse in the past year and no investigations or reports to review.

The facility conducts administrative investigations only. Interviews with the superintendent indicated his knowledge of proper procedure and process and the requirement to keep any resident making an allegation informed of the progress in the investigation and its response to the allegation (staff on leave/moved, etc.) and whether the allegation was substantiated, unsubstantiated or unfounded. Interviews with one of the six facility investigators indicated his knowledge of the facility's requirement to report to residents.

No resident who had made an allegation of sexual abuse was in population at the time of the onsite audit and no allegations of sexual abuse have been made in the past twelve months.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

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

Evidence:

115.376 PREA-Disciplinary Sanctions for Staff.

The facility's policy mirrors the standard. This topic is covered in training of facility staff.

There have been no sexual abuse or sexual harassment allegations against facility staff in the past year and no disciplinary actions taken against staff. (The one allegation of sexual harassment was against a teacher who is a contractor. It was unsubstantiated.)

All documentation reviewed made it clear that staff would be subject to discipline up to and including termination for any infraction under its Zero Tolerance Policy. There were no files to review.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.377 PREA-Corrective Action for Contractors and Volunteers
Interview with superintendent

The facility's policy contains all elements required by the standard.

There have been no reports of sexual abuse against contractors or volunteers. There was one unsubstantiated allegation of sexual harassment against a contractor (a teacher).

The superintendent stated that it would be subject to what the investigation determined and if substantiated, they would prohibit further contact.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

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

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

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

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

115.378 (c)

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

115.378 (d)

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

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

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.378 PREA-Interventions and Disciplinary Sanctions for Residents
Interview with superintendent
Interview with mental health staff

The facility's policy is in compliance with the standard. The policy states that a resident's mental disabilities or mental illness will be considered when determining what type of sanction should be imposed, if any. The policy also states that reports of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying.

This facility prohibits all sexual activity between residents. CJS does not deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

There have been no resident-on-resident allegations of any type in this facility in the past year. There have been no resident-on-staff allegations in the past year. There were no disciplinary records to review.

The facility's mental health staff noted that residents would be offered therapy, counseling or other interventions to address and correct underlying reasons or motivations for sexual abuse. She also noted that a resident's participation would be voluntary and not tied to any other component of the facility's programming.

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

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

115.381 (b)

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

115.381 (c)

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

115.381 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.381 PREA-Medical and Mental Health Screenings, History of Sexual Abuse
Interview with mental health staff
Interview with staff who administers vulnerability assessment
Interview with medical staff
Review of Vulnerability Assessment Instrument
Review of past resident files (reviewed 55 of 211files)

The facility's policy is in compliance with the standard. The interview with the staff member who does vulnerability assessments at intake described system in place for alerting the mental health provider that a referral was indicated. They use a case management computer program to ensure referrals are made.

The Vulnerability Assessment Instrument prompts the staff member who administers it to notify the mental health staff if a resident reports prior sexual victimization or having perpetrated sexual abuse. The email alerts the mental health to offer a follow-up meeting with a mental health or medical provider within 14 days. The review of files of past residents along with the current residents who took part in interviews during the audit found that this is happening consistently. The mental health provider noted during her interview that residents who disclose are often being seen in the community or have been seen in the community. The form provides a good safety check for making sure the required referrals are made in the necessary timeframes.

The facility uses a form which residents sign giving informed consent; if residents are under 18 parents/guardians sign giving permission for treatment.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

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

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

115.382 (c)

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

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.382 PREA-Access to Emergency Medical and Mental Health Services
Interview with nurse
Interview with secure staff

Facility policy includes all elements to be in compliance with the standard. There have been no allegations of sexual assault in this facility and there were no records to review.

The facility's nurse reports that treatment is provided according to her professional judgment. All care is provided at no cost to residents and is provided right away. Access to care would be through the local hospital, Chesapeake Regional Medical Center. She also indicated that residents received treatment right away.

No residents have been victims of sexual abuse at the facility in the past year. Secure staff identified their first responsibility as protecting the victim and securing medical help.

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

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

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

115.383 (c)

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

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (f)

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

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.383 PREA-Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers
Interview with medical staff
Interview with mental health staff

The facility's policy mirrors the standard. There have been no incidents of sexual abuse at this facility.

Interviews with the facility's nurse and mental health provider confirmed that treatment is consistent with community level of care; residents are treated at Chesapeake Regional Medical Center. Medical treatment provided at the facility is under a doctor's direction and after assessment at hospital. Interviews with mental health and medical staff demonstrate knowledge of requirements of the standard. The facility's mental health provider is on staff at CJS.

Residents would receive treatment without financial cost. Resident victims of sexually abusive vaginal penetration while incarcerated would be offered pregnancy tests and timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Any resident who is the victim of becomes pregnant as a result of sexual abuse that occurred at the facility would be offered services right away. Evaluations would be conducted on resident-on-resident abusers within 60 days and treatment offered when deemed appropriate by mental health practitioners.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.386 PREA-Sexual Abuse Incident Review
Interview with superintendent
Interview with PREA Coordinator
Interview with incident review team member

The facility policy and formation of its incident review team mirror standard and contain all elements necessary to be in compliance with the standard.

There have been no incidents of sexual abuse at this facility and there were no reports to review. The superintendent indicated that they would use the guidance in the standard to address the incident and to make changes as necessary depending on the outcome of the incident review. The facility has a good understanding of the intent of the standard.

Interviews with members of the team, PREA coordinator, superintendent indicate understanding and commitment to the intent of the standard.

Standard 115.387: Data collection

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

115.387 (a)

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

115.387 (b)

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

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.387 PREA-Data Collection

The facility's policy and plan for data collection mirrors the standard. There have been no incidents of sexual abuse or sexual harassment in the facility, so no data to collect. DOJ has not requested any data. The facility does not contract with any other facility for the confinement of its residents.

Standard 115.388: Data review for corrective action

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

115.388 (a)

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

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

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

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.388 PREA-Data Review for Corrective Action
Interview with agency head
Interview with superintendent
Interview with PREA coordinator/compliance manager
Review of annual report
Website review: https://www.cityofchesapeake.net/government/city-departments/departments/human-services/Chesapeake-Juvenile-Services.htm

The facility's policy is compliant with the standard. The facility's website contains all elements to comply with the standard.

The annual report is posted on the facility's website and is available to the public. It is seen and approved by the agency head and signed and published under the facility superintendent's signature. The report states its right to redact material from the report such as resident names or any identifying information. The report also describes what it will collect and the way it reviews the data collected for corrective action.

The PREA coordinator/compliance manager indicated that personally identifiable information should be redacted during his interview.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

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

115.389 (b)

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

115.389 (c)

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

115.389 (d)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

115.389 PREA-Data Storage, Publication, and Destruction
Interview with PREA Coordinator

The facility's policy mirrors standard.

In the interview with the PREA Coordinator, he indicated knowledge of the standard and the requirement to both make information publicly available and to remove personally identifying information. He talked about the confidential nature of the information and how it is maintained in a confidential manner and in a secure location.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This facility talked with this auditor about conducting this audit in early March, 2020. The audit was delayed in an abundance of caution in consideration of the COVID-19 Pandemic. Together, this auditor and the facility planned and executed the audit with a focus on doing everything possible to keep the residents, facility staff and this auditor safe. Strategies included delaying the on-site portion of the audit until there was better understanding of the virus itself and allowing time to develop a strategy. No residents, staff or this auditor have been ill since the time of the on-site audit.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Evidence:

Review of facility website

The facility's Final Report issued at the end of this facility's last audit is on its website and available to the public. It was reviewed on the website by this auditor.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Susan P. Heck ______________________ February 18, 2021___

Auditor Signature **Date**

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

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