PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 9/26/17

Auditor Information			
Auditor name: Talia Huff			
Address: 920 W. 12th St Larned, KS 67550			
Email: talia360cc@gmail.com			
Telephone number: 785-766-2002			
Date of facility visit: 3/21/17-3/23/17			
Facility Information			
Facility name: Juvenile Correctional Center-Nampa (JCCN)			
Facility physical address: 1650 N 11th Ave North Nampa, ID 83687			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 208-465-8443			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Lynn Viner			
Number of staff assigned to the facility in the last 12 months: 143			
Designed facility capacity: 84			
Current population of facility: 64			
Facility security levels/inmate custody levels: 4			
Age range of the population: 11-21			
Name of PREA Compliance Manager: April Horak		**Title:** Regional Quality Improvement Specialist	
Email address: april.horak@idjc.idaho.gov		**Telephone number:** 208-921-9503	
Agency Information			
Name of agency: Idaho Department of Juvenile Corrections			
Governing authority or parent agency: *(if applicable)* State of Idaho			
Physical address: 954 W. Jefferson P.O Box 83720 Boise, Idaho			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 208-334-5100			
Agency Chief Executive Officer			
Name: Sharon Harrigfeld		**Title:** Director	
Email address: Sharon.harrigfeld@idjc.idaho.gov		**Telephone number:** 208-860-3045	
Agency-Wide PREA Coordinator			
Name: Joe Blume		**Title:** Correctional Program Coordinator	
Email address: joe.blume@idjc.idaho.gov		**Telephone number:** 208-908-3283	

NARRATIVE

The Idaho Department of Juvenile Corrections (IDJC) contracted for a PREA audit to be conducted of the Juvenile Corrections Center-Nampa (JCCN) on March 21-23, 2017. This is JCCN's second PREA audit. IDJC operates three (3) state run juvenile corrections centers. This audit was led by dual-certified PREA auditor Talia Huff.

The contract was in place early January 2017 and communications regarding the audit began with Joe Blume; the PREA Coordinator, thereafter. The auditor provided Auditor Notices (in English and Spanish) to be posted in all living units, facility entrance, visitation areas, medical and mental health areas, and other common areas. Confirmation of these notices being posted was provided to the auditor on 1/11/17, almost ten (10) weeks prior to arriving on site. Once onsite, it was noted that the Auditor Notices were abundantly posted. Documentation was provided to the auditor via thumb drive prior to the audit, to include the Pre-Audit Questionnaire and supporting documentation. Prior to arrival, the auditor submitted a tentative audit schedule to the facility to outline audit activities for the onsite portion. The first morning of the audit, an opening meeting was held with leadership and support staff, which included Lynn Viner, Superintendent; Joe Blume, PREA Coordinator; April Horak, PREA Compliance Manager. A brief discussion was held regarding the PREA audit process and methodology as well as other audit and facility logistics. Following the in-brief, the auditor was led through the site review. The site review covered all areas, units, and departments of the facility. PREA signs, Auditor Notices, and camera coverage was observed in every living unit, many common areas, facility entrance, and intake. The PREA signs contained the numbers and addresses for the Nampa Family Justice Center as well as the address and phone number for the Idaho Department of Health & Welfare Child Abuse & Neglect Report hotline. The auditor observed residents attending school, witnessed staff interactions, and had informal discussions with residents and staff members. The atmosphere was calm and orderly. Staff were pleasant and aware of PREA and the ongoing audit.

In addition, the auditor also made the following observations:

- The physical plant is conducive to direct supervision; having few blind spots
- Most doors contained a window which increases resident sexual safety
- Placement of security cameras was abundant; approximately 111 cameras
- All rooms are single occupancy
- There are no camera views in rooms or areas where resident may be in a state of undress
- There is a large open outdoor recreation area for residents

The auditor obtained staff and resident rosters with which to select random staff and residents to interview. The staff selected were from varying units, shifts, and rank. Female and male residents were chosen at random from each unit/pod. Interviews were conducted with administrative staff and leadership as well as other specialized staff that perform specific PREA-relevant duties. Additional documentation was requested and reviewed including investigative records, incident reviews, training, education records, and personnel records.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Juvenile Corrections Center-Nampa is a state operated secure juvenile facility that serves adjudicated male and female juveniles ages 11-20 with significant substance abuse issues and co-occurring disorders. The average length of stay is 12-15 months. The facility capacity is 84; the population at the time of the audit being 64.

JCCN offers many programs and a therapeutic community with a focus on positive peer culture. JCCN reported 3 housing units, with 8 total pods. The O&A unit is the intake unit that all juveniles come into for assessment and placement/program determination. The Solutions unit is separated into a male and female side and the Choices unit is comprised of 3 pods (A, B, and C). JCCN offers full time medical and mental health, education, religious, and rehabilitative services. JCCN has an individualized treatment approach with individual and group therapy, drug and alcohol, family counseling and mediation, family enrichment, and cognitive behavioral therapies.

The facility's mission:

> *Our focus at JCC–Nampa is to provide the best care for juveniles committed to Idaho Department of Juvenile Corrections, in partnership with communities. We measure our programs and set goals for future work through our participation in Performance-based Standards (PbS) for Youth Correction and Detention Facilities. PbS is a self-improvement and accountability system used in 27 states to better the quality of life for juveniles in custody. PbS sets national standards for the safety, education, health/mental health services, security, justice and order within facilities, and gives agencies the tools to collect data, analyze the results to design improvements, implement change then measure effectiveness with subsequent data collections.*

SUMMARY OF AUDIT FINDINGS

The agency and facility has prioritized PREA compliance efforts, which was demonstrated throughout the audit and during discussions with leadership at the agency and facility levels. The Agency Head is very supportive of PREA and of the importance of sexual safety. This was also articulated by the Facility Head, PC, and PCM. Investment from the top down was very evident as was a commitment toward the intent of the PREA standards and sexual safety. Corrective action was completed for four (4) standards and was completely satisfied on 9/5/17. Moreover, JCCN has exceeded eleven (11) standards and met twenty-nine (29). One (1) standard is not applicable and no standards remain not met.

Number of standards exceeded: 11

Number of standards met: 29

Number of standards not met: 0

Number of standards not applicable: 1

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- Policy 914 PREA Compliance
- Quality Improvement Organizational Chart
- JCCN Organizational Chart
- Glossary of Terms and Acronyms

Interviews, Document and Site Review:

Idaho Department of Juvenile Corrections (IDJC) has in effect several policies that guide implementation of the PREA standards. Policy 914 PREA Compliance addresses this standard; outlining an overview of agency strategies of PREA compliance, cites the general duties and appointment of a PREA Coordinator and PREA Compliance Managers, and mandates zero tolerance towards sexual abuse and sexual harassment, in part, as such:

> *Incidents of sexual activity, whether consensual or nonconsensual; threats to engage in nonconsensual sexual activity; and solicitation to engage in sexual activity are a recognized problem that can occur in juvenile correctional facilities in the United States. The occurrence of such behavior within the Idaho Department of Juvenile Corrections (IDJC) interferes with the agency's mission and seriously compromises the welfare of the juveniles within the agency's care and custody.*
>
> *It is therefore the policy of IDJC that all facilities and contract providers will adhere to a zero tolerance standard for incidences of sexual abuse or misconduct. Furthermore, it is the policy of IDJC that all allegations of sexual abuse or misconduct within IDJC facilities will be investigated and responded to accordingly. IDJC will provide a coordinated response to incidents of sexual abuse among staff first responders, medical and mental health staff, investigators, and facility leadership.*

Page 1 of Policy 914 identifies 15 points outlining different aspects of the agency's approach to reducing and preventing, detecting and responding to sexual abuse and sexual harassment.

Definitions of prohibited behaviors regarding sexual abuse and sexual harassment are identified in the Glossary of Terms and Acronyms. In general, IDJC policies do not contain definitions, but refer to this glossary. Relevant definitions are: Staff-on-Resident Sexual Abuse, Staff-on-Resident Sexual Harassment, Staff-on-Resident Voyeurism, Resident-on-Resident Sexual Abuse, and Resident-on-Resident Sexual Harassment. These definitions are congruent with the definitions of sexual abuse and sexual harassment in the PREA standards. Furthermore, the policy states that termination is the presumptive sanction for staff that have engaged in sexual abuse and section VIII addresses juvenile education, interventions, and disciplinary sanctions.

Interviews with random staff, residents, and specialized staff affirmed their awareness of the zero tolerance policy and practice as well as measures of prevention, detection, and response.

IDJC has appointed an upper-level Agency PREA Coordinator; Correctional Program Coordinator Joe Blume. Joe's primary responsibility is to develop and oversee agency PREA compliance efforts. He reports that he has sufficient time and has authority to do this and auditor observations corroborated this. The auditor was provided with agency and facility organization charts, which listed the PREA Coordinator (PC) and PREA Compliance Manager (PCM) positions. The charts depict that PREA compliance is under the Quality Improvement Services division in which Joe Blume is the Correctional Program Coordinator/PREA Coordinator and facility QI Specialists/PREA Compliance Managers. For the Nampa facility, April Horak is the designated QI Specialist/PCM. Joe Blume reports directly to the Agency Director, Sharon Harrigfeld, and there are 3 facility PCM's that report to Joe Blume. As the PCM, April Horak reported she has sufficient time and has authority to do this and auditor observations corroborated this. April holds an upper-level position at the facility and works very closely with the Superintendent, but reports to the PREA Coordinator.

Corrective Action:
None.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Contracts for confinement
- Rule Review Worksheet (Site visit tool)
- IDAPA Section 224

Interviews, Document and Site Review:
IDJC does contract for the confinement of residents. There are seven (7) such contracts, with the following entities: Sequel, MANA Services Inc, Empowerment, Bannock Youth Foundation, Bannock House, 5C Residential Treatment, and 3B Residential Treatment. The auditor was provided with these contracts to review. In September 2016, PREA audit corrective actions identified that the PREA contract language was lacking sufficient content. Thus, as of January 2017 new contract language was added and implemented. Now, adequate PREA language existed in all these contracts, which read as such:

The CONTRACTOR must adopt and comply with the PREA standards & acknowledges that IDJC will conduct announced or unannounced compliance monitoring to ensure compliance with the PREA standards. The Contractor will be subject to a Department of Justice (DOJ) PREA audit every three (3) years. The Contractor shall be solely responsible for paying for a PREA audit as required by its contract with IDJC. Failure to comply with PREA standards may result in termination of the contract.

The agency has a robust practice for monitoring contract compliance. IDAPA (Idaho Administrative Procedures Act) outlines IDJC's obligation to monitor their providers. IDAPA PREA Section 224 is the basis for this monitoring and guides annual site visits to check for compliance. In interviews with the Agency Contract Administrator (who is the PREA Coordinator for intents and purposes of this standard), explained the process for this annual monitoring which entails annual in-person visits to each contract provider with a team of 5-7 agency staff which assesses the provider and, using a site visit tool, assigns the provider a score of up to 20 points. The tool and 7 completed annual visits were reviewed by the auditor and corroborated this practice.

January 2017 was the deadline the agency gave for all contract providers to be PREA compliant. Some did not become PREA compliant and, therefore, IDJC residents were removed from those providers.

IDJC exceeds this standard due to the robust procedures and practice in place for monitoring PREA compliance among its providers and for adhering to a strict standard of addressing sexual safety in confinement.

Corrective Action:
None.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Policy 621Duty Officer Responsibilities
- Nampa Staffing Plan 6-22-16
- JCCN Floor plan
- Staffing Plan Assessment
- DO Reports (Unannounced Rounds documentation)
- Weekly Schedules

Interviews, Document and Site Review:
IDJC/JCCN make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. The Nampa Staffing Plan addresses the 11 required elements of provision (a) and states that the Superintendent must approve the staffing plan for each living unit. The staffing plan is predicated on an average daily population of 84 residents, while the reported average daily population since the last audit was 58. The Nampa Staffing Plan contained extensive information about many aspects of staffing which included a breakdown of staffing for each unit and the needs and demographics thereof (i.e. capacity, population composition, staffing, and risk levels). The staffing plan asserts that cells closest to the staff desk are reserved for juveniles that are new to the program, safety security risks, or require closer observations/proximity to staff. It goes on to further expand on the utilization of certain cells, tiers, and pods as they relate to resident supervision. Other aspects of the Staffing Plan include: Observation & Assessment Evaluation/Classification Staffing, Initial Assessment, Intake, O&A Room Assignment, Assessing for Potential Sexually Aggressive Behavior, Re-Assessment Upon Placement, and PREA Supervision Requirements.

Both the Superintendent, PCM, and the PC were interviewed and articulated how the facility complies and maintains adequate staffing levels. Auditor observations while onsite supported the staffing plan and adequate levels of supervision. JCCN reported on the Pre-Audit Questionnaire that they do maintain ratios of 1:8 during the day and 1:16 during sleeping hours, but also stated that the facility is unable to meet the (upcoming) required ratios at this time. It was the auditor's understanding that they currently meet the ratios at times, but not at all times. The Superintendent explained different staffing needs among the different units and that she holds a briefing every morning in which staffing coverage, and any potential deviations, are addressed among other things. It is the Unit Manager for each unit that ensures there is adequate daily staffing. If needed, additional staff are brought in to cover holes and there is a duty officer on call always who would work the floor if needed. The Superintendent discussed her practice of monitoring staffing patterns to assess for any need of adjusting and that it is possible to collapse posts or cancel certain programs if necessary, though that would be an extreme circumstance such as an example of when there was inclement weather and staff could not make it to the facility. In that instance, church service had to be canceled. The Staffing Plan states that during the review period, JCCN has had no findings of inadequacy from federal or external oversight bodies. Additional cameras were added to address blind spots as well as better DVR retention abilities.

The auditor was provided weekly schedules to review staffing and deviations from the staffing plan. The weekly schedules do not support the compliance with the upcoming ratios, but do indicate adherence to the Staffing Plan in place. Listed reasons for deviations from the staffing plan are: trainings, vacations, sick leave, comp time, holiday, FMLA, though, it appears that JCCN did always maintain their current minimum staffing level, at least.

As articulated in interviews and set forth in policy, JCCN reviews their staffing plan at least annually and this is in conjunction with the PC, PCM, Superintendent, and the Agency Director. This Staffing Plan Assessment was provided for review, was dated 10/16/16, depicted the capacity at the time to be 84 and the current population to be 65. It cited the number of staff during the week and on the weekends, the average staffing ratio (which was cited as 1:4 during the day and 1:13 at night), a review of monitoring technologies, review of unannounced rounds, and "resources available and committed to adhering to the staffing plan."

IDJC/JCCN employs a practice of having a duty officer on call at all times, which is rotated among higher level staff members. Policy 621 Duty Officer Responsibilities states, "The DO will conduct and document (in the weekly DO report) unannounced rounds for purposes including but not limited to ensuring the safety and security of juveniles and staff and helping to identify and deter staff sexual abuse and sexual harassment in all areas of the facility, both during day shifts as well as night shifts. The frequency of the rounds will be determined by each facility Superintendent, but not less than twice per rotation."

JCCN demonstrated an institutionalized practice of conducting unannounced rounds and this was evidenced by review of DO Reports and articulated by the PC, PCM, and a higher-level staff member that was interviewed. The staff member that was interviewed could articulate the method and purpose of conducting these rounds; assessing staff behavior, accounting for all residents, being alert to "anything that doesn't seem right," etc. He further asserted that he has never been aware of any practice of staff alerting others of rounds and reported that is not part of the culture at the facility.

Corrective Action:
None.

Standard 115.315 Limits to cross-gender viewing and searches

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Contraband Acquisition and Disposition/Searches Policy 620
- Juvenile Supervision Policy 608
- Non-Discriminatory, Developmentally-Sound Treatment of Lesbian, Gay, Bi-sexual, Transgender & Intersex Youth Policy 672
- O&A Intake Policy 640
- Supervision and Management of LGBTI Residents Powerpoint

Interviews, Document and Site Review:
The Pre-Audit Questionnaire indicated that JCCN does not conduct cross-gender strip searches, body cavity searches, or pat down searches and has had zero (0) such incidents in the 12-month review period. Interviews of staff, residents, and leadership consistently corroborated that there had never been an instance in which it had happened, even in exigent circumstances. Therefore, there were no logs or documentation of cross gender searches for the auditor to review. Several policies address this standard. O&A Intake Policy 640 asserts that upon intake there will be a visual inspection of the resident by same gender staff. Contraband Policy 620 states that pat searches of residents will be conducted only by staff that are the same gender as the youth and witnessed by a second staff of the same gender. Policy 620 also states:

- *"Searches of individual juveniles will be conducted using the quadrant method. This search method consists of dividing the juvenile's body in four quadrants and conducting a pat down search outside the juvenile's clothing on each quadrant."*
- *"When there is reasonable suspicion that a juvenile may be carrying contraband, and with the approval of the superintendent or designee, a visual inspection of a juvenile showering can be conducted*

privately by a nonmedical staff of the same sex pursuant to search procedures as outlined in the Observation and Assessment Intake policy."

Every random resident and random staff interview conducted affirmed this policy language and that there are no cross-gender searches done of any kind.

JCCN has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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. Juvenile Supervision Policy 608 addresses provision (d) in the following way:

Staff will not enter shower/toilet areas or observe juveniles of the opposite sex in shower/toilet areas except in emergencies or when deemed necessary. In situations in which intensive staff supervision in toilet/shower areas is needed to reduce safety and security threats, there must be Unit Manager/designee approval. All staff must provide a reasonable accommodation for privacy for all toilet/shower areas and areas where juveniles change their clothing. Each living area will use a sign that will indicate if juveniles are showering or changing. Staff entering the living area during times juveniles are changing or showering, must announce their presence.

The auditor observed that this is well institutionalized practice. There is one recommendation for this policy language, however, and that is to remove the verbiage "or when deemed necessary," since this standard only allows opposite gender staff to view residents 1) in exigent circumstances, or 2) incidental to routine cell checks. When residents are showering, magnetic signs are put on the outside of the unit door. It was consistently reported that if those signs are up, opposite gender staff generally do not enter at all and, if they do, they announce their presence. Every random resident interview indicated the same and that they felt they had adequate privacy. For toileting, residents have a Velcro laminated cover to put on their room window. Each resident is afforded the opportunity to shower, change clothes, and perform bodily functions without being viewed by staff at all except incidental to routine room checks.

Policy and practice is in place at JCCN that prohibits the search or physical examination of a transgender or intersex resident for the purpose of determining genital status, which is asserted in Non-Discriminatory Policy 672 in section I.A. This was echoed in all staff interviews; they articulated that was not permitted and that leadership would determine measures that needed to be taken, should there be a transgender or intersex resident admitted. There were no transgender or intersex residents at the facility at the time of the onsite audit and none were observed by the auditor. Therefore, none were interviewed for verification.

Provision (f) regarding staff training for cross-gender pat downs is not addressed in policy and it was reported that no staff have received it. Policy prohibits cross-gender pat downs even in exigent circumstances and this was echoed by all staff and residents, therefore, JCCN need not ensure staff have this training. For pat searches of transgender residents, staff receive LGBTI training and there is policy language (Policy 672) that asserts LGBTI or questioning residents will be searched in accordance to the Contraband Policy 620, the dignity of the juvenile shall be maintained at all times, a transgender resident may request which gender of staff they prefer, and that any such search must be conducted in the presence of a witnessing staff. This information is included in the Supervision and Management of LBGTI Residents Powerpoint training, on slides 39 & 40.

The strict culture of prohibiting cross-gender viewing, the privacy afforded to the residents, staff articulation of information related to this standard, and the LGBTI training exceeds this standard.

Corrective Action:
None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- O&A Intake Policy 640
- Juvenile Understanding of PREA (English and Spanish)
- PREA Posters (English and Spanish)
- Translation invoices
- PREA video

Interviews, Document and Site Review:

JCCN takes appropriate steps to ensure that residents with disabilities have an equal opportunity to the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. O&A Intake Policy 640 asserts that if a juvenile is unable or unwilling to read the forms, "intake staff must read and explain the forms to the juvenile. Accommodations will be made for any other disabilities or language barriers." Staff are then directed to email the Clinical Supervisor and education staff to inform them of observed disabilities. Several resources are available to carry this out including bilingual staff, a translation service, and video relay system. Residents participate in a one-hour PREA class every Monday. Generally, the PREA video is shown in addition to the PREA Basics for Juveniles Powerpoint. Some weeks only the Powerpoint is shown. The video is available in English and Spanish. For hearing impaired residents, JCCN has a video relay system. The auditor noted it during the site review. For visually-impaired residents, the audio on the educational video is utilized. For those who have intellectual, psychiatric, or speech disabilities the auditor gleaned information from staff that they would individually ensure comprehension of materials through reading and reviewing the written materials. Also, PREA zero tolerance posters are posted in English and Spanish as well as the Orientation brochure. Residents are provided information about PREA directly upon intake and in fact, the intake/transport officer explained the practice by which they cover certain things with a resident during the transport to the facility; building rapport and making the resident's transition smoother. Part of this discussion entails PREA. The intake/transport officer also explained that a PREA brochure is explained and acknowledgement form is signed. The auditor was able to identify residents with intellectual/cognitive delays with which to interview. These residents were aware of the PREA information and reported that staff did ensure they understood the material.

JCCN takes steps to ensure meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment for limited-English proficient (LEP) residents. Primarily, they use a translation line for LEP. The Agency Head, when interviewed, discussed access to the translation line and that in fact she had used it to talk

with a parent. She also reported that Spanish is the most common non-English language, but that the facility has received more refugees since there are refugee settlement areas in proximity. The auditor was provided with several invoices from different translators and from Linguistica International for translation services that have been provided. The auditor interviewed one LEP resident that reported adequate comprehension of PREA and PREA material upon intake. It was reported by this resident they did ensure she understood.

Policy language on page 2 of the O&A Intake Policy prohibits the use of resident interpreters and JCCN reported zero (0) instances where this has occurred as related to sexual abuse or sexual harassment. Staff interviews consistently conveyed that this is not a practice that occurs at JCCN.

Corrective Action:
None.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Criminal History Background Checks Policy 340
- Personnel records
- Reference Check form

Interviews, Document and Site Review:
Policy 340 outlines the hiring and process for conducting criminal history background checks. It specifically contains the language of provision (a) on page 1. Furthermore, it outlines the system to obtain a complete record search for background and criminal history information, which includes any or all of the following: arrests, prosecutions, disposition of cases by courts, sentencing, probation and parole status, and information relating to offenders received by a correctional agency, facility or other institution. This system applies to "volunteers, student interns, contractors, applicants for initial employment and/or internal promotions, and all current employees."

The process of the hiring process and conducting background checks was explained to the auditor by the Human Resources (HR) administrator. She elaborated on the use of NCIC (nationwide), ILETS (statewide search for driving record and state criminal record), Idaho repository (criminal and civil offenses), Health and Welfare Registry and National Sex Offender Registry, and FBI (fingerprints). JCCN reported that 17 staff were hired in the last year, which went through this hiring and background check process. The auditor verified through a review of these records. The HR administrator explained that incidents of sexual harassment are considered and that the extent to

which it would affect hiring would be dependent on the circumstances and considered on an individual basis. Child abuse registries are checked as indicated above through the Health and Welfare Department as well as the National Sex Offender Registry. As far as contacting prior institutional employers, the HR administrator explained that is completed through the process of reference checks, on the Reference Check form, and is completed by the hiring supervisor. Upon review of the Reference Check form, it was noted that the is a PREA section that consists of 5 questions regarding involvement in sexual abuse or sexual harassment, or resignation prior to the completion of the investigation. The HR administrator recalled an attempt to obtain this information from a neighboring county, but they would not provide the information.

The background check process for interns, contractors, and volunteers is facilitated by the PCM. She reported that fingerprints are sent to FBI, Health and Welfare registries are checked as well as NCIC. State and national sex offender registries are checked as well and once that is all completed and approved, the respective supervisor is notified and control is given approval for entrance into the facility.

The practice and policy on conducting background checks on current employees is "at least every five years." Policy 340 asserts that all employees are subject to subsequent background checks when being considered for promotion, when rehired or reinstated, and any other time it is determined necessary and states that all employees shall have a criminal history background check at least every five years. The HR administrator confirmed this as did a review of records.

Provision (f), regarding asking applicants and employees about misconduct described in (a), is addressed and satisfied by including it in employee annual performance reviews and is records on the Employee Performance Review form.

Language of provision (g) is cited on page 4 of Policy 340. There such instances of material omissions to review.

Lastly, provision (h) is cited in Policy 340 on page 8 Section VIII Future Employment References. The HR administrator reported that if they received such a request, the information would be provided, but she did not have examples for verification.

Corrective Action:
None.

Standard 115.318 Upgrades to facilities and technologies

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
JCCN reported on the Pre-Audit Questionnaire there had been no expansions or modifications to the facility since August 20, 2012. They reported there had been updates to video monitoring, which consisted of enhancing camera coverage. Interviews with the Agency Head affirmed her commitment to sexual safety and that PREA compliance is an ongoing process. She confirmed there had been no expansions or modifications to the facility and that video monitoring is a supplement to direct supervision and to cover blind spots identified in the facility. She contended that PREA is now "just part of our process" and part of the budget.

Corrective Action:
None.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- Sexual Assault Policy 835
- Correspondence with the Nampa Police Department
- Documentation of Qualified Staff Member
- MOU's with Nampa Family Justice Center
- Documentation of records

Interviews, Document and Site Review:
IDJC/JCCN has agency investigators that conduct administrative investigations of all non-criminal allegations of sexual abuse and sexual harassment. The PC, PCM, Agency Head, and Facility Head conveyed their practice of referring allegations to local law enforcement, which occurs any time an allegation involves potential criminal conduct. These criminal investigations are referred to the Nampa Police Department (PD). JCCN relies upon local law enforcement for the collection of evidence that maximizes potential for obtaining useable physical evidence. PREA Policy 914 contains language, though, to mandate staff to preserve and protect evidence on the alleged victim or abuser and in the location of the incident until appropriate steps can be taken by law enforcement to collect it. This protocol is reportedly adapted from the NIC (National Institute of Corrections) course: Investigating Sexual Abuse in

a Confinement Setting. Though not *required* by this standard, it is a recommendation to attempt to ascertain the uniform evidence protocol used by the Nampa PD and to enter into an MOU to outline sexual abuse response details between the two agencies.

Forensic exams are obtained, free of cost, for any alleged victim of sexual abuse through the Nampa Family Justice Center (NFJS). NFJS employs certified Sexual Assault Nurse Examiners (SANE's) to conduct the forensic exams. JCCN has had an MOU in place with NFJS, which is renewed each year the most recent being signed in February 2017. Two MOU's were provided for auditor review and outlined obligations between the two agencies. One MOU outlines victim services in the event of an allegation of sexual abuse. Through discussions with the PC and the Director of NFJS, it was learned that it is implied that while this MOU does not speak to providing forensic exams, it is implied in the term "victim services." The second MOU outlines emotional support services and the understanding that NFJS will offer a victim advocate for accompaniment through the forensic exam process as well as confidential emotional support services. Sexual Assault Policy 835 is the agency policy that guides the procedures for obtaining forensic exams, documentation thereof, etc. There were no sexual abuse allegations during this reporting period that warranted a forensic exam or requests for confidential emotional support services.

Interview with the PCM conveyed communications with the NFJS as well as with local law enforcement and the auditor was provided with correspondence to Nampa PD and from the PCM regarding the requirements of the PREA standards as they relate to local law enforcement and requesting that they follow provisions (a)-(e) of this standard.

Provision (g) of this standard is not applicable for determining this facility's compliance and for provision (h), the auditor was provided credentials for a staff member that has been screened for appropriateness to serve as a qualified staff member pursuant to this standard. Documentation consisted of a resume, transcripts, and a letter of intent that showed a background and education in the field of victim advocacy/support and counseling.

Corrective Action:
None.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- Investigative files

Interviews, Document and Site Review:
IDJC/JCCN does ensure an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. That was clear and evident to the auditor. Through interviews with the Agency Head, PC and PCM, random staff and residents, and informal discussion throughout the onsite audit it was evident that allegations of sexual abuse and sexual harassment are taken seriously and are acted upon right away. In the past 12 months, JCCN reported on the Pre-Audit Questionnaire that there were fifty-one (51) allegations of sexual abuse or sexual harassment and fifty-one resulted in administrative investigation. One of those were referred for prosecution. The auditor was provided with a PREA Incident Summary; a document containing a spreadsheet of all the reported allegations. The PREA Incident Summary identified the origin, type, and disposition of each of the 51 allegations. Thirty-two (32) of the allegations were determined to be "not a PREA," leaving 19 remaining. Upon discussion with the PC and PCM, it was learned that this meant that the alleged conduct did not meet the PREA and policy definition of sexual abuse or sexual harassment. An example was that it was an isolated incident in which a sexual comment, or potentially sexual comment, was made but did not meet the repeated and unwelcome threshold of the definition. Of the 19 remaining allegations, four were disposed as unfounded (3 resident-on-resident, 1 staff-on-resident), two unsubstantiated (resident-on-resident and staff-on-resident), two (resident-on-resident) substantiated, and eleven were determined to be "non-abusive contact" and not assigned a disposition.

The auditor selected investigative files of every type for review and verification of completion of the investigation.

PREA Investigations Policy 911 mandates and elaborates on the agency's obligation to ensure investigations are completed for every allegation of sexual abuse and sexual harassment and this policy, pursuant to provision (c) is published on the agency website and delineates responsibilities between IDJC and the investigating entity: http://www.idjc.idaho.gov/?s=prea

Provision (d) is not applicable in determining PREA compliance of this facility.

Provision (e) is not applicable in determining PREA compliance of this facility.

Corrective Action:
None.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

- Refresher-Direct Care PREA Training Powerpoint
- PREA Basics for First Responders Training
- LGBTI Training Powerpoint
- Training records

Interviews, Document and Site Review:
PREA Policy 914 charges the PC with ensuring all staff, volunteers, interns and contractors receive training on IDJC's sexual abuse response procedures.

The PCM explained that new staff receive basic PREA training online, on their first day. Within the first 2 weeks, they receive live training that is delivered by the PCM. Current staff receive refresher training annually in which they receive an email prompt to complete. The auditor was provided curricula and training material to include the PREA Basics for First Responders Powerpoint. The curriculum addressed all eleven (11) required elements of provision (a) (although, not specified in policy). Staff interviews indicated that there was a depth of PREA knowledge. Staff articulated the elements of this standard well and that they receive this training annually. Policy does not specify the frequency or content of the PREA training and although this is not *required,* it is recommended and could be strengthened by doing so. JCCN also utilizes a posttest to assess comprehension. JCCN reported on the Pre-Audit Questionnaire that 123 employees that had received the training during the review period. The auditor reviewed training records to verify the completion of training. Training verification printouts were provided for all staff.

Training is tailored to both genders, as both genders reside at JCCN. Employees are all trained on cross gender supervision, so additional training in the event of facility reassignment is not necessary. Staff receive refresher training annually, which exceeds this standard. This was corroborated in random staff interviews. One year after completing Basic PREA Training, staff are prompted via email to complete annual training electronically.

Verification of training as required by this standard and interpretive guidance is satisfied by an acknowledgement statement on the training roster for new staff that receive the in-person training. For online training that new staff receive as well as current staff receiving refresher training, there is an acknowledgement statement as part of the training quiz which states they understand the training they have received. The staff must check the "yes" button to complete training. The auditor reviewed training records and quizzes verifying this practice.

Corrective Action:
None.

Standard 115.332 Volunteer and contractor training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Direct Care PREA Training
- Training records

Interviews, Document and Site Review:
All Volunteers, Interns & Contractors receive the same PREA training as staff; Direct Care PREA Training. The PCM is charged with providing training to volunteers, interns, and contractors, which she explained is done in person and then take the posttest. The auditor reviewed the training material and quiz, which contains the required elements of employee training as required and elaborated in standard 115.331. The training exceeds what is required in this standard. A selection of volunteer/intern/contractor training records was requested and received and verified this practice.

All volunteers, interns, and contractors receive the same amount of training, which is that of which all staff receive and, therefore, exceeds this standard.

Corrective Action:
None.

Standard 115.333 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Juvenile Orientation Brochure
- Juvenile O&A Handbook
- PREA Understanding of PREA information/acknowledgment form
- PREA video
- PREA Basics for Juveniles Powerpoint
- PREA Education records
- PREA Education Dates spreadsheet

Interviews, Document and Site Review:
Upon intake, residents receive PREA information on the agency's zero tolerance policy and how to report such incidents among other things. Initial PREA information is delivered by an Intake Officer and was thoroughly

articulated by the intake officer interviewed; explaining that he begins discussing the intake process (including PREA) during the transport to the facility, inquires about their level of PREA knowledge, and once at the facility explains the juvenile brochure, handbook, and acknowledgement form and then has them sign it. There is minimal information about PREA in the Juvenile Handbook, which

> *The Prison Rape Elimination Act (PREA) supports the elimination, reduction and prevention of sexual assault and rape within corrections systems. The act establishes a zero-tolerance standard for the incidence of offender sexual assault and rape.*
>
> - *Sexual assault is a crime.*
> - *All sexual contact between residents is prohibited.*
> - *All sexual contact between staff and residents is prohibited.*
> - *All allegations will be investigated.*

The Juvenile Orientation brochure provides abundant language regarding methods of reporting and response. The handbook acknowledgement form reiterates residents' ability to use the grievance process or the Child Welfare hotline to report. The PREA Basics for Juvenile Powerpoint that is shown to residents explains the definitions of sexual abuse and sexual harassment. Thus, via these multiple methods of resident education, all relevant and vital information is conveyed to residents, not only at intake but also on a weekly basis.

JCCN reported that 114 residents were admitted and received comprehensive education during the review period. Of the 114 residents admitted, 112 residents were provided the PREA information within 10 days of intake. All juveniles at JCCN have been educated within a year of March 21st, 2017. PREA Education Dates spreadsheet documents resident education by tracking the dates in which it was received and whether it was completed within 10 days. There were 114 entries, 2 of which indicated they had not received the PREA information within 10 days. This meets substantial compliance. JCCN should continue to endeavor to provide this information to all residents within 10 days if intake.

As noted in the auditor comments of 115.316, resources are available for providing resident education in formats that are accessible to LEP (Limited-English proficient) residents as well as disabled residents or those that have limited reading skills, or the like. As stated on the Pre-Audit Questionnaire, JCCN has resources for hearing and visually impaired residents including the Video Relay System for the visually impaired and audio from the resident education video for hearing impaired. For LEP residents, the Juvenile Understanding of PREA acknowledgement form is available in Spanish, the PREA posters around the facility, and the Orientation brochure. There is also access to a translation service which was discussed by several staff including the PC, PCM, and Agency Head.

For those who have intellectual, psychiatric, speech disabilities (or otherwise) the auditor gleaned that information would be conveyed individually by reading and ensuring comprehension of the written materials. The facility keeps PREA information continuously and readily available to residents via posters throughout the facility. This posted in formation was observed throughout the site review by the auditor. Signage was posted in both English and Spanish and were in each living unit, in hallways, classrooms, etc.

Residents were well informed about PREA, their rights to be free from sexual abuse and sexual harassment, and reporting methods. All residents randomly selected for interviews articulated that they were provided information upon intake about PREA. They also conveyed a comfort and level of trust in reporting sexual abuse and sexual harassment to staff and reiterated the weekly PREA class that is delivered.

The frequency of the PREA information delivered, on a weekly basis, exceeds this standard.

Corrective Action:
None.

Standard 115.334 Specialized training: Investigations

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- NIC Training: Investigating Sexual Abuse in Confinement
- Certificates of Completion
- Training List

Interviews, Document and Site Review:
JCCN has provided specialized training to a pool of staff, though, the PCM generally conducts investigations of cases that do not involve a forensic exam/evidence collection or involve criminal behavior. Those that involve criminal actions are referred to Nampa Police Department.

There were 17 staff that completed specialized training, from the National Institute of Corrections (NIC) titled Investigating Sexual Abuse in a Confinement Setting. The auditor was provided with all certificates of completion. Not all 17 individuals conduct investigations, though, as enhanced education all supervisors are required to take this course. This NIC course covers all the required elements of investigation training including Garrity warnings, proper use of Miranda, evidence collection in confinement settings and evidence required to substantiate a case. It is, however, recommended that anyone who conducts sexual abuse investigations receive additional investigative training beyond this one online course.

The PCM April Horak was interviewed as the investigator at JCCN. She is primarily responsible for PREA investigations and articulated the investigative process and the coordinated response of an allegation, which was comprehensive. April has very good understanding of the PREA standards and the intent behind them. Her explanation of all aspects of sexual abuse and sexual harassment investigations adhered to the true spirit of the PREA standards and elements of specialized training. April's articulation of the investigations along with the enhanced education for all supervisors exceeds this standard.

Corrective Action:
None.

Standard 115.335 Specialized training: Medical and mental health care

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Specialized Training for Medical and Mental Health Powerpoint
- Training List

Interviews, Document and Site Review:

JCCN has 13 medical and mental health staff and reported that all have received specialized training. The specialized training is delivered via Powerpoint and contains all required elements of this standard and additional topics as well such as: information about the PCM and her duties, first responder duties, aspects of prevention and response planning, JCCN's coordinated response, medical care, responding to LEP and disabled residents, responding to the resident's physical and emotional state, access to outside emotional support, PREA investigations and types of evidence, and mental health services. JCCN also has 3 medical/mental health contractors and 12 interns that all received this specialized training.

The auditor was provided electronic documentation of all medical and mental health staff receiving this training and interviewed a mental health and medical staff while onsite. The mental health staff had also taken the general PREA training as well as the NIC investigative training and articulated aspects of all the trainings. This along with the content of the Specialized Training for Medical and Mental Health Powerpoint exceeds this standard.

Corrective Action:

None.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- O&A Intake Policy 640
- O&A Evaluations Policy 404
- Non-Discriminatory, Developmentally Sound Treatment of Lesbian, Gay, Bisexual, Transgender, and Intersex Youth Policy 672
- Risk of Sexual Victimization/Perpetration (RSVP)
- Observation and Assessment Evaluation
- RSVP Score breakdown

Interviews, Document and Site Review:
JCCN has a policy that requires screening residents upon intake for risk of sexual victimization and abusiveness. O&A Intake Policy 640 outlines procedures upon intake and mandates the use of the Risk of Sexual Victimization/Perpetration (RSVP), as such:

> *The juvenile will be administered the Risk of Sexual Victimization/Perpetration (RSVP) screener within 72 hours of intake by clinical staff. Clinical staff will share the results of the screener with appropriate staff via an e-mail. Results of the screener will also be documented on the O&A Evaluation in the testing section as well as Section 3, the Unique Placement Considerations heading.*

The RSVP is conducted among several other assessments during the intake process. Review of completed RSVP forms indicated that they are completed within 72 hours; generally, the same day as admission. They are conducted by clinical staff; one designated clinician conducts the majority of them. The Pre-Audit Questionnaire indicated that 103 RSVP's were completed during this review period. Policy language regarding periodic reassessment was not found and while there are monthly staffing reviews, these reviews do not address sexual risk or potential changes thereto.

Provision (b) of this standard requires that the screening instrument be objective. The RSVP contains a scoring mechanism and culminates in an overall score for risk of vulnerability to sexual victimization and an overall score for propensity toward sexually aggressive behavior.

Provision (c) of this standard requires 11 different elements to consider, at a minimum, to screen for a resident's risk of sexual victimization or abusiveness. The RSVP accounts for all required elements except for considering a resident's identification as lesbian, gay, bisexual, transgender, or intersex. Currently the RSVP considers "gender nonconforming appearance/behavior" but does not inquire and about LGBTI status. Pursuant to interpretive guidance by the Department of Justice, a facility must affirmatively inquire about LGBTI status and make both an objective and a subjective determination about risk in this area; whether a resident *is* LGBTI or whether the resident *is perceived to be* LGBTI. Further elaboration can be found on the PREA Resource Center website under the FAQ page. Therefore, the auditor finds that the RSVP is lacking this requirement. Additionally, upon the observation of this screening being conducted, the auditor noted that in practice this information about LGBTI status and gender nonconforming appearance is not adequately obtained. Review of completed screenings did not note consideration of this either. Of note, however, IDJC has a policy that addresses procedure when a resident identifies as LGBTI, though, it was not affirmatively asked of the resident nor articulated by screening staff. Part of the language is as follows:

> *Upon disclosure by a juvenile to a staff member that he/she is LGBTI or questioning their gender or sexual orientation, staff will talk with the juvenile in an open and understanding manner, and will refer the juvenile*

to program or clinical staff. Staff will explain to the juvenile IDJC's commitment to non-discrimination/anti-harassment as it relates to the juvenile's safety and will notify the juvenile's facility case manager of the disclosure.

The auditor observed that most of the screening information is obtained in-person and entails a file review. The RSVP indicates questions that shall be obtained through file review. Additionally, as indicated in policy cited above and through conversations with the clinical staff that conducts the RSVP, the screening information is not readily shared and is available to staff if/when it is related to treatment or safety of the resident.

The auditor was provided with a breakdown of screening scores, which revealed the appearance of a disproportionate number of residents that had been designated as having a risk for perpetration. Discussions were had with the PC and leadership regarding the screening process and their plans to revamp the screening, scoring, and categorization of the RSVP. This change would likely be more beneficial to the facility and the ability to better inform decision-making in this area.

Corrective Action:

1. IDJC/JCCN shall revise the screening process to ensure that it includes proper consideration of LGBTI status and also that gender nonconformity is specifically and adequately considered by clinical staff.
2. Provide auditor with verification of implementation of the revised screening as well as training/education for clinical staff regarding the revision and enhanced assessment of gender nonconformity.
3. Implement a system of periodic reassessments that considers the RSVP and any changes to sexual risk. This could be incorporated into an existing system perhaps.

Update on Corrective Action:

1. The auditor and PC had ample discussion and correspondence regarding corrective action for this standard. It was discovered that the clinician that was interviewed by the auditor; the clinician that conducts the majority of the RVSP screenings, was inadvertently using an outdated version of the RSVP form. As of the onsite audit, and the discovery of this issue, this practice was rectified and the clinician replaced all outdated versions with the current version of the RSVP form, which properly accounts for the consideration of LGBTI status as well as gender nonconformity. In fact, Prior to the audit the RSVP screener had been scheduled to undergo revision now that the agency had over 2 years of data. The PC reported, "Among other updates, question #6 on the revised screener specifically separates out identification as LGBTIQ as a vulnerability factor from the other scored vulnerabilities due to its elevated significance as a factor likely to solicit harassment/abuse in a confinement setting."
2. Though the screening process itself was institutionalized, in order to demonstrate institutionalization of the revised RSVP, the auditor requested completed RSVP screenings that spanned a period of time once the RSVP revisions had been fully implemented. The revised RSVP became available to clinicians on July 10th, 2017, and was fully implemented (i.e. with training) in late July. August 2017 was the first full month it was consistently used throughout the agency. There were 10 resident admissions in August to JCCN. On 9/5/17, all 10 completed RSVP screenings were provided for auditor review and demonstrated compliance with this corrective action. The PC indicated that this change had been implemented agency-wide and provided completed screenings for the month of August from the other two juvenile facilities as well.
3. The PC advised that policy language regarding periodic reassessment would be enhanced. The enhanced policy language was provided for auditor review and approved. It stated, "Juveniles shall be screened for risk of sexual victimization/perpetration using the Risk of Sexual Victimization/Perpetration Screener (RSVP) (DJC-269) form by a mental health professional within 72 hours of O&A intake. In order to guide placement and management strategies the RSVP shall also be administered at least every 6 months after the date of placement." On 9/5/17, the auditor was provided with completed reassessments, which supported and demonstrated the practice outlined in the enhanced policy language.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- O&A Intake Policy 640
- O&A Evaluations Policy 404
- Non-Discriminatory, Developmentally Sound Treatment of Lesbian, Gay, Bisexual, Transgender, and Intersex Youth Policy 672
- Special Management Interventions Policy 604
- Risk of Sexual Victimization/Perpetration (RSVP)

Interviews, Document and Site Review:

JCCN has processes in place to use screening information to inform decisions about housing, bed, program, education, and work assignments of residents. Several policies and procedures guide this. As asserted in policy, and corroborated in interviews with the PC, PCM, and clinical staff that conduct screenings, clinical staff will share the results of the screener with appropriate staff via an e-mail and results of the RSVP are also documented on the O&A Evaluation in the testing section as well as Section 3, the Unique Placement Considerations heading. Upon review of completed screenings and O&A Evaluations, the auditor gathered that placement considerations are documented and the information obtained from the RSVP is utilized in decision making. Additionally, measures are in place to consider and accommodate residents in order to address individual safety needs and to keep them safe and separated from potential abusers. For example, residents designated as high risk for victimization can be placed in the cells closest the staff desk for better supervision and proximity to staff. The pods/living units have certain assignments such as residents that are younger, residents that have exhibited sexual misconduct, residents that have conduct disorders, etc. Possible placement options are discussed with staffing participants. Policy 404 asserts, "When recommending placement, consideration is given to the specific needs, behaviors, and vulnerabilities as indicated by screeners and assessments completed during the O&A process. The Clinician inputs these recommendations in the ICLA as outlined in the 407 policy/procedure."

The placement recommendation then goes through a process of review and approval. This, too, is outlined in Policy 404.

It was evident to the auditor that JCCN uses isolation as a last resort. Instead they employ measures such staff- or resident-imposed room time or, in some cases, a resident may be placed in the vestibule, which is a glass-enclosed area that enables constant direct supervision. This is generally used for suicide observation and is short-term. This is

outlined in Policy 604 Special Management Interventions, which states:

> *It is the policy of the Idaho Department of Juvenile Corrections (IDJC) that use of an intervention which results in room confinement, isolation or segregation from their current treatment program is to be used solely as an adjunct to the treatment process when a juvenile's behavior seriously endangers the safety and security of others or the facility. There will be documentation that all other lesser restrictive means to control behaviors and maintain safety and security have been exhausted. Use of juvenile room confinement, isolation, or segregation for behavioral management as a means of arbitrary imposition of punishment will not be tolerated.*

Auditor observation onsite and interviews supported this to be practice at JCCN. JCCN reported zero (0) instances of resident isolation and no isolation used to protect residents from sexual abuse. Policy 604 also mandates and outlines procedures for due process if a resident is isolated and "additional due process" for time exceeding 24 hours, which is documented using the Due Process Hearing Documentation form. Leadership and staff reported information consistent with policy language and affirmed that isolation is not really used at all. This practice and documentation satisfies provisions (h) and (i). There were no records to review and verify since there were no isolations during the review period. Residents that were interviewed reported the practice of room time, but not isolation.

Policy 672 addresses provision (c) regarding the placement of LGBTI residents. Interviews and auditor observations confirmed that LGBTI residents are not placed in a designated unit. There were no identified transgender or intersex residents, nor any observed by the auditor. The auditor did interview 2 lesbian/bisexual residents and was given information that was consistent with policy and practice as it was discussed with leadership. Pursuant to provision (d) Policy 672 asserts, "When making a placement decision, placement staff shall consider whether a transgender or intersex juvenile would prefer to be placed with males or females and the reason for that preference, with the final decision for placement being made by the Clinical Supervisor and/or Program Manager." This policy also states that transgender and intersex residents will be reassessed for risk of sexual victimization every 6 months. The auditor gathered that the PC and/or PCM ensure the Rehabilitation Specialist solicits information about a transgender/intersex resident's view of their safety, twice per year. Though there were no transgender residents at the time of the audit or during the review period, screening staff that were interviewed alluded to monthly staffing reviews, but did not articulate that it would be specific to transgender/intersex residents and reassessing sexual risk. Further clarification obtained from the PC affirmed that this process is done and is documented. The PC stated that the process only involves the resident and their primary case manager/clinician. The PC also indicated that transgender residents have been very few, so this process has rarely been done throughout the agency. The PCM advised that there is a current process at the facility in which a clinical meeting occurs that "involves Rehabilitation Specialists, Unit Managers, Clinicians & Clinical Supervisors. This meeting is documented & every juvenile is discussed every 4 to 6 months. At the point in time when a transgender/intersex juvenile is up in that rotation the requirement of this standard, as evidenced in policy, would occur." The auditor received several examples of the Clinical Meeting minutes to evidence that there is an institutionalized practice whereby every juvenile receives a clinical review. If the facility has a transgender/intersex resident, the Clinical Meeting will review and reassess the resident's view of their safety and if their level of safety has changed. Historically, prior to this audit, JCCN has had 3 transgender residents in which this review was completed.

Not only does Policy 672 cite that a transgender resident's own view regarding their safety be taken into consideration, discussions and assessment of the facility culture affirmed that this would be the case in the event that a transgender or intersex resident was admitted. Residents are JCCN can shower separately, whether transgender or not, since the showers are enclosed and accommodate only one resident at a time.

Corrective Action:
None.

Standard 115.351 Resident reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Privileged Communications Policy 675
- Solutions Program Manual
- Juvenile Grievance Process
- PREA posters
- Juvenile Orientation brochure
- Juvenile Handbook
- Juvenile Understanding of PREA acknowledgement form

Interviews, Document and Site Review:

JCCN provides multiple internal ways for residents to privately report sexual abuse or sexual harassment or retaliation for reporting such incidents. The Privileged Communications Policy 675 outlines juvenile's rights as they relate to communications and correspondence such mail, telephone, visitation, legal counsel, reports of sexual abuse and harassment (page 2), and access to outside victim advocacy services (page 3). This policy elaborates on how these resources are accessible and staff obligations related thereto. There is an excellent reporting culture that was evident to the auditor. Methods of report are emphasized during intake and throughout a resident's stay.

The auditor learned that residents can report to any staff member, call the Child Welfare hotline, write a grievance or note, tell a counselor or administrator, and report externally via mail. Residents consistently articulated ways to report sexual abuse or sexual harassment. There was a trust of staff that was conveyed through resident interviews. Staff, too, could articulate the multiple ways in which residents are able to report.

The facility provides at least one way for residents to report externally to a public or private entity. That entity is the Child Welfare and is specified in Policy 675 on page 3 in the following way:

III. Reports of Sexual Abuse/Sexual Harassment

In the event a juvenile desires to report an incident of sexual abuse/sexual harassment through a means outside of IDJC, they shall be allowed to do so and the communication shall be considered privileged.

1. *If a juvenile wishes to report by phone, staff will follow the same procedures and afford the juvenile the same level of privacy as described in section I.A.*

2. *Juveniles may submit sealed mail which is addressed to the Child Abuse/Neglect Reporting Agency. Juveniles may remain anonymous when using this method of reporting and are not required to include a return address.*

3. *IDJC has identified the following outside agency to receive these reports. The outside agency immediately forwards the juvenile reports of sexual abuse/sexual harassment to IDJC's statewide PREA Coordinator. The outside agency that has been identified is:*

   Child Protection, 1-855-552-5437
   FACS-Central Intake
   1720 Westgate Drive
   Suite A, Boise Id. 83704

JCCN does not detain residents solely for civil immigration purposes.

The hotline that is accessible to residents (and staff) goes directly to the Child Protection. Most residents have frequent access to and visits from the probation officer, which they could report externally to. Many residents also disclosed that they would report to friends or family that they have visits and/or phone calls with.

Staff accept all reports of sexual abuse and sexual harassment and act upon them immediately. Through interviews, the auditor found evidence that supported this as practice. All reports are documented. Staff are required to report immediately or at least before the end of shift if not emergent. Evidence of this practice being institutionalized was obtained through interviews of random staff and random residents.

Residents are provided with a method and tools necessary to make a written report. Residents can do this via grievance forms which can be put into the locked grievance box. Residents and staff alike reported this to be implemented in practice.

Staff have many methods to report sexual abuse and sexual harassment of residents. Most staff articulated these methods well and reported they would likely report to their immediate supervisor. Staff also reported they would feel comfortable reporting to any member of administration.

Privately and/or confidentially, staff can also report to the Child Protection hotline. Most staff were aware of this method, though, they felt it would not be necessary.

The articulation of the multiple methods of report by staff and residents along with the thorough outlining of this in the Privileged Communications Policy 675 exceeds this standard.

Corrective Action:
None.

Standard 115.352 Exhaustion of administrative remedies

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Juvenile Grievance Policy 671
- Grievance form
- Orientation brochure
- O&A Juvenile Handbook
- Juvenile Grievance Policy Memorandum of Understanding

Interviews, Document, and Site Review:
Upon admission to JCCN, each resident participates in an orientation and the grievance process is explained. Juvenile Grievance Policy 671 mandates that residents be informed of it within 24 hours of arrival. The resident completes and signs the Juvenile Grievance Policy Memorandum of Understanding form. The juvenile acknowledges by signing the form that he/she understands the grievance process. The intake staff also signs and dates the form. Furthermore, Policy 671 thoroughly outlines the grievance process and addresses all aspects of this standard. There is a section at the end that contains routing, tracking, and logging grievances specific to JCCN.

Locked grievance boxes are located in each living unit, in education, and in food service. The Safety and Security Supervisor (or designee, in their absence) has access to the boxes. Grievance forms are available to all residents without having to ask a staff member and envelopes are made available to put the forms in when they are completed by the juvenile. Grievance boxes are checked daily.

A section about using a grievance as a method of report is found in the Juvenile Orientation Brochure. It states that an informal resolution is not required and another point cited therein is, "Grievances about a PREA incident will immediately be given to a special person to investigate."

The Juvenile Grievance Policy 671 states:

> *For PREA related circumstances including allegations of substantial risk of imminent sexual abuse, no initial attempts of resolving through problem solving with the treatment group and/or team is necessary and the juvenile may file the grievance, checking the "Sexual Abuse/Sexual Harassment" box on the top of the form and/or on the envelope.*

Any grievance with the "Sexual Abuse/Sexual Harassment" checkbox marked on the envelope is considered an emergency grievance at JCCN and Policy 671 mandates "an initial response, including immediate corrective action that may be necessary, will be provided within 48 hours."

The O&A Handbook (pages 10 &11) cites the grievance process and the Juvenile Understanding of PREA acknowledgment form used at intake also cites grievance being one of the methods of report. No time limits are imposed for submitting grievances.

Interviews with residents indicated that they were well informed about the grievance process and most listed it as one of the multiple methods of report. JCCN reported there was 1 sexual abuse/sexual harassment grievance during the review period, which resulted in a final decision within 90 days. No extensions were needed or requested, though

Policy 671 asserts that the juvenile shall be informed in writing if an extension were needed. There was one emergency sexual abuse grievance filed during the review period which resulted in resolution within 48 hours. Response times outlined in the Grievance Policy 671 exceed that required in this standard.

Regarding provision (g), there were no bad faith grievances filed, but Policy 671 states," If it is found that a juvenile intentionally filed an emergency grievance where no emergency exists, an appropriate program response may be initiated."

Corrective Action:
None.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Privileged Communications Policy 657
- O&A Juvenile Handbook
- PREA Basics for Juveniles PowerPoint
- PREA posters
- NFJS MOU's

Interviews, Document and Site Review:
Outside confidential support services have been established for residents at JCCN. They are provided by the Nampa Family Justice Center (NFJS) and are outlined in two different MOU's; one for victim services pursuant to a sexual abuse allegation and one pursuant to sexual abuse counseling as required by this standard. The MOU's were provided for review. Each year it is renewed with the most recent renewal being in February 2017. The Privileged Communications Policy 657 outlines resident rights to contact NFJS as well as the method for doing so. Residents are allowed private and "privileged" communications as stated in Policy 657. They can submit a sealed letter and can remain anonymous.

The PREA posters on display throughout the facility contain the contact information (phone and mailing address) for NFJS. In addition, The PREA Basics Powerpoint used for resident PREA education contains this information as well, on slide 9. The Pre-Audit Questionnaire stated that this information was also located on page 11 of the O&A Handbook, although, the auditor did not find it there. Nevertheless, the information is abundant. Not all residents reported an awareness of these services, as indicated through interviews. However, some residents did and this, along

with this information being so abundantly available, JCCN meets substantial compliance.

Corrective Action:
None.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Agency website
- O&A Handbook
- PREA posters

Interviews, Document and Site Review:
It was clear that JCCN has an established practice to receive third-party reports of sexual abuse and sexual harassment. PREA posters are visible to third parties (visitors, etc.), which contain reporting information. On the agency website, there is a "contact us" form/link available to third parties. In fact, the website has a unique feature which is that a Reporting Abuse blurb is located on the right side of the page that remains there regardless of any link or tab that one goes to. Directly under that is the "contact us" link. The website is: http://www.idjc.idaho.gov/?s=prea

Also, parents/guardians receive a copy of the Juvenile Handbook which has limited PREA information, but no methods of report or contact information for doing so. The handbook could be enhanced by including this, but is not required.

Interviews with several residents indicated that they were very aware that they could use or be a third party for reporting. Staff indicated they were aware also.

Corrective Action:
None.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
PREA Policy 914 mandates staff to report immediately any knowledge or suspicion of sexual abuse or sexual harassment as well as retaliation and staff neglect of duties. Staff are required to report immediately to their supervisor or other leadership. Interviews of all staff – random, specialized, and administrative – indicated this to be an institutionalized practice.

Mandatory child abuse reporting laws are emphasized in training and staff articulated that during interviews. Indicated in staff interviews, staff members are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Staff indicated things like an allegation "should be kept quiet" or should not be "common knowledge."

Medical/mental health employees are required to follow the same policy and shall be required to inform juveniles at the initiation of services of their duty to report and the limitations of confidentiality. The auditor observed an intake/screening between a clinician and new resident. The limits to confidentiality were disclosed to the resident and an interview with a mental health staff affirmed this to be the practice.

Upon learning of a report of abuse, it is the PCM's duty to ensure notification of the parents of the residents involved within 24 hours and this is mandated by Policy 914 on page 3.

Corrective Action:
None.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
It was clearly indicated in interviews with staff that immediate action is taken to protect a resident that is in imminent danger of sexual abuse. There are several options that can be utilized, if needed, such as just leaving the resident in his/her room, moving the resident to another part of the facility, using the vestibule, etc.

There was no event during the review period that would cause such actions to occur. JCCN reported there to be no instances of residents being in imminent danger of sexual abuse. The residents all reported that they felt confident that staff would not let anything bad happen to them, if they could help it.

Corrective Action:
None.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Reporting documentation

Interviews, Document and Site Review:
Page 5 of PREA Policy 914 addresses this standard, as such:

IX. Upon suspicion of and/or becoming aware of a possible sexual abuse incident that is reported to have occurred at another facility:

A. The Superintendent of the facility where the juvenile is located, or the IDJC Director, shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred, and shall also notify the appropriate investigative agency.

B. Such notification shall be provided as soon as possible, but no later than 24 hours after receiving the allegation.
C. The PREA Coordinator shall document that such notification has been made.

JCCN asserted they had received no reports from other confinement facilities. During interviews, neither the Facility Head nor the Agency Head recalled receiving reports of sexual abuse that occurred at another facility, though, they articulated that receiving such an allegation would initiate the reporting and response protocol like any other allegation received within the facility; it would kick off an immediate report to law enforcement (if warranted) and/or internal investigation. Documentation was provided, however, of one instance in which a JCCN resident reported an incident at another facility. Documentation consisted of a PREA Review form detailing the report and response as well as emails from the PCM.

Corrective Action:
None.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
Page 3 of PREA Policy 914 cites this standard.

The Pre-Audit Questionnaire indicated there were six (6) allegations of sexual abuse during the review period and in three of those instances, the alleged victim and abuser were separated. One allegation was reported within a time period that allowed for the collection of evidence. The first responder took steps to protect the scene, but the Pre-Audit Questionnaire indicated that the alleged victim and abuser were not given instructions not to destroy evidence. Additionally, there was one incident in which the first responder was a non-security staff member. In this incident, security staff was notified, but instructions not to destroy evidence were not given.

Interviews with staff revealed that staff's ability to adequately articulate first responder duties pursuant to this standard lacked somewhat in the area of instructing alleged victims and abusers not to take actions that could destroy evidence.

The auditor did interview a staff member who acted as a first responder and indicated that she had immediately

notified the Duty Officer and separated the residents by putting them in their rooms (although their rooms were directly across from each other, so there were visual and possible audio capabilities between them). This staff did not report that she gave instructions not to destroy evidence, although, that may not have been necessary due to the nature of the incident.

Corrective Action:

1. Staff training shall be enhanced or emphasized with information regarding the preservation of evidence, particularly that could be on the body or clothing of the alleged victim and abuser. Provide auditor with documentation of such training.

Update on Corrective Action:

1. The PC reported the following in response to the corrective action:
   - *During this reporting period there were 2 substantiated incidents, 1 unsubstantiated incident & 3 unfounded incidents. The substantiated contact was brief & occurred in front of staff (buttock grab & breast pinch), it was not prudent or necessary to instruct staff to preserve or gather evidence.*
   - *In the single incident where preserving & collecting evidence was prudent, staff ensured it occurred. The incident was later confirmed to be unfounded through video review.*
   - *If an allegation involves criminal conduct (which if we are considering preserving physical evidence is most likely to be the case) than it is LE [Law Enforcement] that will do the evidence collection. We can open up the training to see where this can be emphasized.*
   - *Mrs. Horak [PCM] will train in team meetings the expectations of evidence preservation. This will be documented & provided.*

   On 7/11/17, the auditor received minutes from the facility's team meetings evidencing that the PCM had reviewed with staff their responsibilities to preserve evidence in the event that an allegation may indicate that forensic evidence preservation is necessary.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Institutional Plan for Responding to PREA Incidents

Interviews, Document and Site Review:

Policy language can be found on page 1 of the PREA Policy 914 that mandates a coordinated response pursuant to this standard.

The auditor was provided with an Institutional Plan for Responding to PREA Incidents, which is specific to JCCN and coordinates actions among staff first responders, medical/mental health, investigators, and facility leadership. It is a checklist style document that outlines response requirements; notifications, preservation of evidence and crime scene, contact information for St. Luke's Cares Center and Nampa Family Justice Center, etc.

Corrective Action:
None.

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

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
This standard is not applicable. There is no collective bargaining in this facility.

Corrective Action:
None.

Standard 115.367 Agency protection against retaliation

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

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

must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Harassment and Discrimination Policy 307
- Quality Improvement Staff Handbook
- Sexual Abuse/Harassment Retaliation Monitoring form

Interviews, Document and Site Review:
Harassment and Discrimination Policy 307, page 6, addresses retaliation against residents as such:

V. Retaliation

Any type of retaliation against any victim, complaining employee, witness, or anyone involved in a complaint is strictly prohibited. The IDJC will follow up any complaint or investigation as appropriate to assure that no retaliation occurs. Employees should immediately report any retaliation under the complaint procedure set forth in this policy. The IDJC will not tolerate retaliation and will take prompt and immediate steps to eliminate retaliation.

Harassment and Discrimination Policy 307, page 6, addresses retaliation against staff as such:

VI. Investigations
All investigations will be conducted in accordance with the Investigations - Administrative (910) policy and procedure. Investigation of a complaint will normally include conferring with the parties involved and any named or apparent witnesses. All employees shall be protected from coercion, intimidation, retaliation, interference, or discrimination for filing a complaint or assisting in an investigation. If the investigation reveals that the complaint is valid, prompt attention and disciplinary action will be taken designed to immediately stop the harassment or discrimination and to prevent its recurrence.

Methods for monitoring retaliation are further outlined in the Quality Improvement Staff Handbook. This Handbook designates the PCM as the staff charged with this monitoring and outlines the process which includes all requirements of the standard. The PCM discussed her method of monitoring retaliation. This includes making sure they are still going on passes in the community or home, looking for an increase in incident reports, restraints, room confinement, or room changes. She also reported that in-person status checks occur about once a month. Furthermore, she indicated that monitoring begins upon receiving the allegation; through the investigation. Even if it is determined "not a PREA," she still monitors those incidents as she feels that resident is still at risk for retaliation (especially if it involves staff). She also discussed one resident that did report retaliation and described her follow up thereafter. The PCM was intuitive about potential retaliation against staff; looking for schedule changes, asking them if they feel isolated from the team, etc.

Monitoring occurs for at least 90 days *from the last indication of any retaliation.* This exceeds the standard in addition to the fact that both sexual abuse and sexual harassment allegations that are substantiated, unsubstantiated, and unfounded are monitored. The PCM clearly exceeds the requirements of this standard and exhibits its true intent.

Examples of monitoring retaliation were requested, provided, and reviewed by the auditor. The requests were generated from a strategic selection of investigations. Upon review, it was completely thoroughly. This documentation is completed on the Sexual Abuse/Harassment Retaliation Monitoring form which is broken down by Week 1, Week 2, and so on. Each week's monitoring consists of check boxes: Reviewed DR's, Reviewed housing changes, face-to-face contact, reviewed program changes, reviewed performance evaluations, and reviewed staff

reassignments. Then there is a comments section to note changes in any of the areas indicated by the check boxes.

Corrective Action:
None.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Special Management Interventions Policy 604

Interviews, Document and Site Review:
Segregation was not used at JCCN within the last 12 months to protect any resident who was alleged to have suffered sexual abuse. As stated in the comments of standard 115.342, JCCN's practice of using isolation as a very last resort was clearly and articulated and evident to the auditor.

It was evident that JCCN uses isolation as a last resort. Instead they employ measures such staff- or resident-imposed room time or, in some cases, a resident may be placed in the vestibule, which is a glass-enclosed area that enables constant direct supervision. This is generally used for suicide observation and is short-term. This is outlined in Policy 604 Special Management Interventions, which states:

> *It is the policy of the Idaho Department of Juvenile Corrections (IDJC) that use of an intervention which results in room confinement, isolation or segregation from their current treatment program is to be used solely as an adjunct to the treatment process when a juvenile's behavior seriously endangers the safety and security of others or the facility. There will be documentation that all other lesser restrictive means to control behaviors and maintain safety and security have been exhausted. Use of juvenile room confinement, isolation, or segregation for behavioral management as a means of arbitrary imposition of punishment will not be tolerated.*

Auditor observation onsite and interviews supported this to be practice at JCCN. JCCN reported zero (0) instances of resident isolation and no isolation used to protect residents from sexual abuse. Policy 604 also mandates and outlines procedures for due process in the event that a resident is isolated and "additional due process" for time exceeding 24 hours, which is documented using the Due Process Hearing Documentation form. Leadership and staff reported information consistent with policy language and affirmed that isolation is not really used. This practice and documentation satisfies provisions (h) and (i) as well. There no records to review and verify since there were no isolations during the review period. Residents that were interviewed reported the practice of room time, but not

isolation.

Corrective Action:
None.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- Investigative files

Interviews, Document and Site Review:
JCCN investigates administrative allegations of sexual abuse and sexual harassment and does so promptly, thoroughly, and objectively for all allegations including third party and anonymous reports. Internal administrative investigations are generally conducted by the PCM. As noted in standard 115.322, there were 51 allegations of sexual abuse and sexual harassment; 19 of those met the proper definition. As noted in 115.364, there were 6 investigations of sexual abuse during the review period. All appeared to be thorough and prompt, as articulated by the interviews of investigative staff and evident upon file/case review. As noted in standard 115.334, the PCM articulated her investigative process very well and conveyed an understanding of the spirit and intent behind the PREA standards. Not only the PCM, but all supervisory staff have completed specialized training.

Interviews of leadership, supervisors, and random staff supported that third party and anonymous reports are handled in the same manner as all other allegations; taken just as seriously. The auditor did not interview criminal investigators as they are external to the facility, as there were none referred for prosecution. The auditor reviewed a strategic selection of investigations and had discussion with the PCM about them.

Interviews and document reviews indicated that the role of the PCM (as investigator) may include the gathering of direct and circumstantial evidence, generally in the form of electronic evidence and/or other pertinent information the facility may have. An investigator at JCCN would not conduct compelled interviews since that would pertain to local law enforcement pursuant to a criminal investigation. If there is support for criminal prosecution, the investigation would be in the hands of local law enforcement. It would be their responsibility to consult prosecution prior to conducting compelled interviews. Interviews and discussion with the PC, PCM, and other staff indicated that persons involved in an investigation are not judged or treated with any bias. The established environment exuded one of respect for all residents, void of unjustly assessing one's credibility. The facility uses no polygraph examinations

with residents under any circumstances.

Any investigations conducted at JCCN are uniformly documented on the PREA Juvenile Interview form and the PREA Incident Review form. The report includes the documentary evidence used in determining the case findings. Detecting staff neglect or violation of duties was conveyed by the PCM. Substantiated allegations that appear to be criminal are referred for prosecution, though, there were none during this review period. The PCM knew that the departure of an alleged victim or abuser does not serve as basis for terminating an investigation. The auditor reviewed a selection of cases that included resident-on-resident sexual abuse, staff-on-resident sexual abuse, substantiated, unsubstantiated, and unfounded. They appeared to be prompt and thorough and exhibited the facility's coordinated response; offering medical/mental health in each one and inquiring about the resident's feeling of safety.

Provision (l) is not applicable to determining this facility's PREA compliance.

When an allegation is investigated externally, the facility remains informed of the progress of the investigation by phoning or emailing the Nampa PD.

Corrective Action:
None.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- Glossary of Terms and Acronyms

Interviews, Document and Site Review:
Through interviews with the PC and PCM, along with investigative file review, it was evident that JCCN uses the standard "preponderance of evidence" to determine whether allegations of sex abuse are substantiated. The investigations reviewed indicated the case dispositions assigned and they appeared to be justified. Case dispositions are defined in the Glossary of Terms and Acronyms. In addition, this is addressed in PREA Investigations Policy 911 on page 1.

Corrective Action:
None.

Standard 115.373 Reporting to residents

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Investigations Policy 911
- Juvenile Receipt of Notice of Findings
- PREA Incident Review form

Interviews, Document and Site Review:

There is only minimal policy language for this standard, on page 2 of Policy 911. It states that the resident will be notified of the outcome of the investigation, but nothing further outlining the expectations for it in practice. However, the auditor gathered that JCCN has an institutionalized practice of notifying residents of the outcome of a PREA investigation pursuant to this standard. This is documented on the Juvenile Receipt of Notice of Findings form. There is a separate form for resident-on-resident investigations (Section D of the PREA Incident Review form) and one for staff involved investigations (Section E of the PREA Incident Review form). Each respective form contains the elements required by this standard and in each of the investigations reviewed, the Notice of Findings was completed. There is a checkbox that reads, "I acknowledge I have received notice of the investigation results." The resident should check this box and then sign/date the form below that. The receipt is provided to the resident whether the allegation was determined to be unfounded, unsubstantiated, substantiated, non-abusive contact, or not a PREA incident. Therefore, this has exceeded this standard.

Corrective Action:

None.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Investigative file

Interviews, Document and Site Review:
PREA Policy 914, on page 1, has language addressing this standard, as follows:

A. The IDJC will comply with all mandatory reporting laws. The IDJC will contact law enforcement and any relevant licensing bodies when staff, volunteers, interns or contractors violate IDJC sexual abuse or sexual harassment policy, unless the activity was clearly not criminal.

B. All resignations in lieu of terminations for violations of agency sexual abuse or sexual harassment policies shall be reported to law enforcement agencies and any relevant licensing bodies, unless the activity was clearly not criminal.

C. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse, subject to Idaho rules and statutes and IDJC policies regarding due process.

JCCN reported that no staff had violated sexual abuse/sexual harassment policies during the review period. There was one staff allegation, but it was determined to be unfounded. The auditor reviewed this investigation. The unfounded case disposition appeared to be justified. Therefore, there were no records to review for verification. However, the auditor gathered that the culture of the agency and facility is one that adheres strictly to zero tolerance and this was evidenced through interviews and conversations with the Agency Head, Facility Head, PC, PCM, and others.

JCCN reported that disciplinary actions against staff are commensurate with the nature and circumstances surrounding the violation and that termination was presumptive for a staff member that engaged in sexual abuse with a resident. Again, there were no records to review for verification.

Corrective Action:
None.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Incident Review forms

Interviews, Document and Site Review:
PREA Policy 914 applies the same language to volunteers, interns, and contractors regarding PREA policy violation as it does all staff. This is found on page 1.

During the review period, JCCN reported 2 contractors/volunteers had violated sexual abuse/sexual harassment policy and were reported to law enforcement. The incidents reported did not occur at the JCCN facility, but rather a contracted residential provider. Therefore, no remedial measures were taken. Discussions with the PC indicated that PREA allegations that occur at contracted providers are reported to him timely and that he conducts a review and provides direction for follow up or quality improvement when needed. The auditor was provided with documentation on both incidents in which a PREA Incident Review was conducted with corrective actions imposed. One was determined "not a PREA" and the other unsubstantiated.

Corrective Action:
None.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- O&A Handbook

Interviews, Document and Site Review:
IDJC has policy that cites most provisions of this standard, which is found in PREA Policy 911 and reads as such:

A. *The IDJC prohibits all sexual activity between residents. Following an administrative finding that a juvenile(s) engaged in juvenile-on-juvenile sexual abuse, or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse, the IDJC will provide appropriate discipline.*

B. *Disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the juvenile's disciplinary history, and the sanctions imposed for comparable offenses by other juveniles with similar histories.*

C. *The disciplinary process shall consider whether a juvenile's mental disabilities or mental illness contributed to their behavior when determining what type of sanction, if any, should be imposed.*

D. *The IDJC will only discipline a juvenile for sexual contact with staff upon a finding that the staff member did not consent to such contact.*

E. *For the purpose of disciplinary action, a report 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, even if an investigation does not establish evidence sufficient to substantiate the allegation.*

There is a formal disciplinary process used at the facility and sexual acting out is considered a major rule infraction. A resident will be subjected to disciplinary sanctions only pursuant to the formal disciplinary process outlined above, following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. There were 2 findings of resident-on-resident sexual abuse during the review period, but neither resulted in criminal findings of guilt. Upon review of the investigative case files, resident-on-resident sexual abuse investigations were reviewed and congruent with this information.

JCCN reported, and the auditor concurred, that disciplinary sanctions are 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. JCCN does not isolate residents, in practice, and there were no instances of such during the review period. Nevertheless, daily large-muscle exercise or access to any legally required educational programming or special education services is never denied. There is further elaboration about resident isolation in standard 115.342 and 115.368.

Interviews with the PC, PCM, and mental health staff affirmed the process for imposing discipline and that the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The treatment side is heavily involved in all aspects of residents' stay. Discipline is determined collectively by the team.

JCCN offers a specialized unit that focuses on treatment and programming for sex offenders, therefore, to that end counseling or other interventions designed to address and correct underlying reasons or motivations for abuse are offered depending on resident eligibility. However, not as a condition to access to general programming or education. O&A Evaluations Policy 404 addresses these services as:

G. Evaluating Juveniles with Sexual Misconduct

1. Juveniles committed to the IDJC for sexual misconduct, or with substantiated documentation of such behavior, receive a psychosexual evaluation if a previous assessment has not been completed within six months of the date of the commitment. The juvenile and parents, if appropriate, complete the Informed Consent for Psychosexual Evaluation/Sex Offense Risk Assessment (DJC-268) form. The psychosexual assessment follows the format and content as outlined in the Sexual Offender Management Board (SOMB) standards for juvenile psychosexual assessment.

2. *Juveniles recommitted to the IDJC for non-sexual offenses, who have previously completed a sexual offense-specific program while in IDJC custody, are reassessed for risk to reoffend sexually. Based upon this reassessment, the juvenile may or may not be required to complete a full sexual offense-specific program.*

3. *Juveniles committed to the IDJC for sexual misconduct or with substantiated documentation of such behavior, receive an in-depth, sexual offender-specific, individual assessment which includes sexual offense-specific conditions and which identifies essential elements of the treatment plan related to the individual juvenile's identified risk to offend sexually. If a previous assessment of the type described above has been completed within six months of the date of the commitment or disclosure, that assessment meets the standard established in this section.*

As set forth in policy, a juvenile may be disciplined for sexual contact with staff only upon finding that the staff member did not consent to such contact. There have been no such instances at this facility. In addition, a report 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, even if an investigation does not establish evidence sufficient to substantiate the allegation. This was a clear part of the culture at JCCN.

All sexual activity between residents is strictly prohibited and will result in discipline action against residents for such activity. This is outlined in the O&A Handbook and is posted on the walls as a "cardinal rule." However, such activity between residents does not constitute sexual abuse if it is determined that the activity is not coerced.

Corrective Action:
None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- O&A Evaluations Policy 404
- Observation & Assessment Report
- Notification of Limited Confidentiality
- Risk of Sexual Victimization/Perpetration (RSVP) screening

Interviews, Document and Site Review:
As described in 115.341, the RSVP is completed within 72 hours of admission by clinical staff (O&A Evaluations Policy 404), therefore, upon disclosure of sexual victimization or perpetration, the resident is with clinical staff. Clinical staff conduct a plethora of assessments and compile the O&A Evaluation Report, which documents resident needs, areas of concern and treatment, and additional referrals if needed. The Pre-Audit Questionnaire indicated, "When a disclosure of prior abuse occurs & services are offered by Medical & Mental Health staff, this is documented in the Observation & Assessment report, or the IJOS contact notes & /or on a Notification of Disclosure (IDJC 131) form."

This is an institutionalized practice and was explained in detail by clinical staff during interviews. It was apparent during interviews of leadership as well as random staff that any information related to sexual victimization or abusiveness be limited to those, as necessary, to inform treatment plans and security decision, etc. Clinical staff explained that following the completion of an intake and O&A Evaluation, it is relayed only to leadership and/or the respective unit manager or other pertinent staff.

All residents admitted to JCCN are ages 10-21. In all cases, residents are informed of, and sign a notice of their limited confidentiality. It must be reported pursuant to mandatory reporting laws and the Juvenile Notice of Limited Confidentiality form informs the resident of this.

Corrective Action:
None.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914

Interviews, Document and Site Review:
JCCN does ensure that residents receive timely access to emergency medical treatment and crisis intervention as they employ clinical staff which are located at the facility and are generally available each day. Medical staff is also employed by and located at the facility. Medical staff are present every day and ensure that are medications and medical needs are met. Crisis intervention and trauma-informed care was a clear and accomplished goal at the facility. In addition to that, JCCN has an MOU established for providing outside sexual abuse counseling and a qualified staff member available as well (see also standard 115.53). Therefore, immediate and unimpeded medical services are provided when necessary. Upon review of investigative files and an interview of a resident who reported sexual abuse, the auditor gathered that this an institutionalized practice at JCCN.

As noted in standard 115.364, staff first responders would take preliminary steps to protect the victim and immediately notify the appropriate medical and/or mental health staff.

Pursuant to a forensic exam, Nampa Family Justice Center offers emergency contraception and STI prophylaxis and follow up thereafter would be completed by medical staff at the facility in accordance with doctor's orders.

Both practice and policy indicate that these services would be provided without cost to the victim, whether the victim names the abuser or not.

Corrective Action:
None.

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

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

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Nampa Family Justice Center MOU

Interviews, Document and Site Review:
JCCN employs medical and mental health staff that provide appropriate medical and mental health care to resident victims of sexual abuse, but also by virtue of the MOU with Nampa Family Justice Center for victim services and sexual abuse counseling.

The clinical staff that was interviewed reported that the level of care is above what is offered in the community and the auditor concurs in light of onsite observations. Investigative documentation included evidence of medical and mental health services offered by the facility staff.

Per protocol at the NFJS, sexual abuse victims are offered pregnancy tests (if applicable), treatment and prophylaxis for STI's as appropriate. All these services are offered without cost to the victim. There were no instances that warranted these services during the review period. The NFJS MOU provided for review accounted for this standard.

For evaluating known resident-on-resident abusers, The O&A Evaluations Policy outlines practice as such:

G. Evaluating Juveniles with Sexual Misconduct

1. *Juveniles committed to the IDJC for sexual misconduct, or with substantiated documentation of such behavior, receive a psychosexual evaluation if a previous assessment has not been completed within six months of the date of the commitment. The juvenile and parents, if appropriate, complete the Informed Consent for Psychosexual Evaluation/Sex Offense Risk Assessment (DJC-268) form. The psychosexual assessment follows the format and content as outlined in the Sexual Offender Management Board (SOMB) standards for juvenile psychosexual assessment.*

2. *Juveniles recommitted to the IDJC for non-sexual offenses, who have previously completed a sexual offense-specific program while in IDJC custody, are reassessed for risk to reoffend sexually. Based upon this reassessment, the juvenile may or may not be required to complete a full sexual offense-specific program.*

3. *Juveniles committed to the IDJC for sexual misconduct or with substantiated documentation of such behavior, receive an in-depth, sexual offender-specific, individual assessment which includes sexual offense-specific conditions and which identifies essential elements of the treatment plan related to the individual juvenile's identified risk to offend sexually. If a previous assessment of the type described above has been completed within six months of the date of the commitment or disclosure, that assessment meets the standard established in this section.*

Corrective Action:
None.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Incident Review form
- QISB (Quality Improvement Services Bureau) Handbook

Interviews, Document and Site Review:
IDJC conducts sexual abuse incident reviews and this process begins prior to the conclusion of the investigation. Several policy excerpts from Policy 914 speak to this process:

- *The IDJC will conduct incident reviews following an allegation of sexual abuse or harassment in order to identify opportunities to protect potential victims from sexually aggressive juvenile offenders in an effort to reduce the incidence of sexual abuse.*
- *[The PC ensures] Within 30 days of concluding the PREA investigation, conducting a PREA incident review with appropriate staff. This is documented on the PREA Incident Review (DJC-262) form.*
- *Within 5 days of learning of a sexual abuse or sexual harassment allegation, the Facility PCM shall complete Section B of the PREA Incident Review (DJC-262).*

There are several sections that comprise the PREA Incident Review form. Each section may be filled out by different people; generally, the PC and the respective facility PCM. The Section A is the Initial Report Summary and indicates the disposition of the investigation (unfounded, unsubstantiated, substantiated, non-abusive contact, or not a PREA incident). Section B (as alluded to in the above policy excerpt) is titles Sexual Abuse Incident Review in which there are the headings of the six required elements of this standard. Section C, Survey of Sexual Victimization (SSV), indicates the type of investigation pursuant to the SSV. Section D is the Juvenile Receipt of Notice of Findings (residents). Section E is Juvenile Receipt of Notice of Findings (staff). Moreover, the auditor interviewed the PC and PCM regarding this review process and learned that the PCM completes Section B by themselves and it was unclear that this part involves input form others. The auditor noted that the QISB Handbook dictates, "In consultation with the DAG [Deputy Attorney General], the Agency PREA Coordinator will complete DJC 262 (PREA Incident Review) no later than 30 days after a PREA report is received. A 262 shall be completed for all PREA reports received. For reports received which are determined not to have met the definition of a PREA incident a DJC form 262 shall document the reason the report was determined not to have met the definition of a PREA incident."

Several people are involved and review the form and complete different sections, but not collectively. It seems the aspect of collective review, as intended by this standard, may be lacking. Upon review of completed incident reviews, 3-5 people were listed as the review team, but it was understood that the form is passed from person to person. It is recommended that it be done collectively. Correspondence with the PC regarding this process was as follows:

> *The collective review of the Incident Review includes line supervisors, medical & mental health staff, etc. This review does not occur through a scheduled meeting, but e-mail sharing of the incident review document.*
>
> > *The interview is conducted by a trained PREA investigator.*
> > *The interview notes are provided to the Agency PREA Coordinator.*
> > *The Agency PREA Coordinator types up a summary of the following:*
> > *The initial allegation*
> > *The findings*
> > *The corrective action*
> > *If the allegation/report is substantiated or unsubstantiated, the PREA Coordinator requests that the Facility PREA Compliance Manager (PCM)complete Incident Review questions (standard 115.386 (d)*
> > *The Facility PREA Compliance Manager consults with the internal treatment team to complete those questions & returns the Incident Review document to the Agency PREA Coordinator for review & approval.*
> > *If approved, the Agency PREA Coordinator returns the draft Incident Review to the Facility PCM & Superintendent for final review (last opportunity for feedback from line supervisors, medical & mental health staff, etc. before becoming the official record.*
> > *The investigation information is used to determine corrective actions & answer the incident review questions.*
>
> > *Direction will be given to the Facility PCM's to schedule a physical meeting with upper-level staff,*

line supervisors, investigators, and medical or mental health, subsequent to a substantiated or unsubstantiated in order to review the incident.

Eighteen (18) incident reviews were completed during the review period. The sexual abuse incident review process is an institutionalized practice.

Corrective Action:
None.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- PREA Incident Summary

Interviews, Document and Site Review:
IDJC collects data from every allegation of sexual abuse and sexual harassment using the definitions set forth in their policy (congruent with the PREA standards) as well as definitions set forth in the Survey of Sexual Victimization. These definitions are included in the Glossary of Terms and Acronyms and the PREA Incident Review form. The PC is charged with the collection of this data. Data is collected, aggregated, and utilized in many ways. It is compiled on the PREA Incident Summary spreadsheet, which was provided for auditor review. In addition, the Survey of Sexual Victimization (SSV) is completed and submitted to the Bureau of Justice Statistics on an annual basis.

IDJC also collects sexual abuse data from each of the contracted facilities who house inmates for the department. The PC is also charged with the collection, review, and response to this data (PREA Policy 914, page 2). The PC and Agency Head discussed the use of data to identify trends in reporting, etc. The Agency Head reported that it informs any need to change policy or practice.

Corrective Action:
None.

Standard 115.388 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- Annual IDJC PREA Report 2016
- Agency Website

Interviews, Document and Site Review:
The auditor was provided with the agency's Annual PREA Report. The report is comprehensive. It identifies problem areas, contains aggregated PREA data and illustrates comparative data tables from previous years (2012-2016). The report contains PREA History, identifies proposed corrective actions at the agency level and at the facility level, contract provider data, 2016 findings summary, and "moving forward."

The report was put together by the PREA Coordinator and was reviewed and approved by the Agency Head. The Agency Head confirmed her review and approval of PREA Annual reports. 2016 Annual Report is posted on the department's public website: http://www.idjc.idaho.gov/prea

The information contained in the IDJC Annual PREA Report along with the extensive and comprehensive PREA data and information on the agency website exceeds this standard.

Corrective Action:
None.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy 914
- QISB Handbook
- Agency website
- IDJC Annual PREA Report

Interviews, Document and Site Review:
The QISB Handbook states, "The Agency PREA Coordinator shall retain all written reports related to PREA allegations 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 and applicable law requires a shorter period of retention. All documentation shall be maintained in a secure location."

This seems to contradict the requirement in this standard, which requires data be retained at least 10 years.

Data from contract providers is contained in the IDJC Annual PREA Report and is published on the agency website: http://www.idjc.idaho.gov/prea

Corrective Action:

1. IDJC shall retain sexual abuse data for at least 10 years.

Update on Corrective Action:

1. The PC admitted this to be an oversight. The agency PREA Policy 914 has been corrected to reflect the 10 year requirement and this was provided to the auditor on 6/9/17.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Talia Huff _____ 9/26/17

Auditor Signature Date