

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim Final

Date of Interim Audit Report: May 14, 2020 N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: June 30, 2020

Auditor Information

Name: Dwight Sadler **Email:** dwightsadler@yahoo.com

Company Name: Click or tap here to enter text.

Mailing Address: 105 Colthorpe Ln. **City, State, Zip:** Hutto, TX, 78634

Telephone: 512-233-9808 **Date of Facility Visit:** 1/13-1/16/2020

Agency Information

Name of Agency: Idaho Department of Juvenile Corrections

Governing Authority or Parent Agency (If Applicable): State of Idaho

Address: 954 W. Jefferson Street **City, State, Zip:** Boise, Idaho 83720

Mailing Address: P.O. Box 83720 **City, State, Zip:** Boise, Idaho, 83720

The Agency Is: Military Private for Profit Private not for Profit

Municipal County State Federal

Agency Website with PREA Information: <http://www.idjc.idaho.gov/prea>

Agency Chief Executive Officer

Name: Monty Prow

Email: monty.prow@idjc.idaho.gov **Telephone:** 1-208-577-5412

Agency-Wide PREA Coordinator

Name: Joe Blume

Email: joe.blume@idjc.idaho.gov **Telephone:** 1-208-577-5409

PREA Coordinator Reports to: **Number of Compliance Managers who report to the PREA Coordinator:**
Director Monty Prow 3

Facility Information

Name of Facility: JCC-St. Anthony

Physical Address: 2220 East 600 North

City, State, Zip: St. Anthony, Idaho

Mailing Address: 2220 East 600 North

City, State, Zip: St. Anthony, Idaho

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <http://www.idjc.idaho.gov/prea>

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

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

ACA

NCCCHC

CALEA

Other (please name or describe: [Click or tap here to enter text.](#))

N/A

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

Facility Administrator/Superintendent/Director

Name: Skip Greene

Email: skip.greene@idjc.idaho.gov

Telephone: 1-208-624-3462

Facility PREA Compliance Manager

Name: Katie Withers

Email: katie.withers@idjc.idaho.gov

Telephone: 1-208-624-3462

Facility Health Service Administrator N/A

Name: Shalaine Edwards

Email: shalaine.edwards@idjc.idaho.gov

Telephone: 1-208-624-3462

Facility Characteristics

Designated Facility Capacity:

128

Current Population of Facility:	109	
Average daily population for the past 12 months:	128	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	13 years old to 21 years old	
Average length of stay or time under supervision	16.7 months	
Facility security levels/resident custody levels	1-5	
Number of residents admitted to facility during the past 12 months	82 new admissions	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>72 hours or more</i> :	80	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>10 days or more</i> :	80	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	168	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	15	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	8	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	8	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	59	

Physical Plant

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	27
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	6
<p>Number of single resident cells, rooms, or other enclosures:</p>	52
<p>Number of multiple occupancy cells, rooms, or other enclosures:</p>	0
<p>Number of open bay/dorm housing units:</p>	4 open bay living units
<p>Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):</p>	4
<p>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

<p>Are medical services provided on-site?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are mental health services provided on-site?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input checked="" type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)
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Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
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When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
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Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input checked="" type="checkbox"/> Local police department <input checked="" type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A
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Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	24
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When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: <i>Select all that apply</i>	<input checked="" type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
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Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input checked="" type="checkbox"/> N/A
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Audit Findings

Audit Narrative (including Audit Methodology)

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

Introduction

The Prison Rape Elimination Act (PREA) audit of the JCC-St. Anthony facility was conducted January 13-16th, 2020. JCC-St. Anthony is a secure facility operated by the Idaho Department of Juvenile Corrections (IDJC) and is located in St. Anthony, Idaho. The audit was conducted by Department of Justice Certified PREA auditors Dwight Sadler.

This was the third PREA audit of the JCC-St. Anthony facility; the previous audit occurred on September 12-15, 2016. The St. Anthony facility became fully PREA compliant after it was determined that four corrective actions had been fully implemented.

No barriers hindered the audit process, and the auditor was provided pre-audit documentation uploaded to a thumb drive through the mail for initial review. The documents were organized into folders that corresponded to each section of the audit compliance tool. Phone calls and emails were shared with the JCC St. Anthony PREA Compliance Manager and the IDJC PREA Compliance Coordinator. During the on-site portion of the audit, the auditor was granted full access to the following:

1. Staff members and youth who were selected to be interviewed just prior to the on-site portion of the audit
2. Youth and staff members during informal interviews during the facility inspection
3. All areas in the facility including the 27 buildings, and all closets, offices, individual rooms, restrooms, and storage areas in each building
4. All relevant documents requested prior to and during and following the on-site audit.

The audit process was discussed with the Compliance Coordinator and the Compliance Manager, through emails and phone calls. All parties understood that the purpose of the audit was to determine compliance with each PREA Standard and that to make the necessary determinations, the auditor would need access to supporting documentation, staff and youth, and all areas of the facility and campus. Following the on-site audit, the auditor discussed the possible corrective actions and the interim and final reports timelines with the Compliance Coordinator, Compliance Manger, and the facility Superintendent.

Pre-Audit

Pre-audit preparation included sending the PREA audit notification postings to the facility Compliance Manager and verifying the notices were posted at least six weeks prior to the audit and included the necessary auditor contact information. The Compliance Manager provided photographs time stamped November 18, 2019, of the audit notices posted throughout the facility. English and Spanish versions of the audit notices were posted more than forty five days prior to the audit, and the postings contained all of the required information. The auditor received no correspondence from the JCC - St. Anthony youth or staff.

Planning emails, phone calls, and text messages began October 30th and continued up until the January 10th, just before the start of the on-site audit. Ongoing communication occurred between the auditor, the agency PREA Coordinator and the facility PREA Compliance Manager. Discussions included audit logistics, the audit process, and timelines such as the interim report date and the length of any potential corrective action period.

Facility and agency information, including the Pre-Audit Questionnaire (PAQ), IDJC policies and procedures and documentation supporting compliance with each standard was uploaded on a thumb drive and mailed to the auditor for review during the pre-audit period. The thumb drive was received by the auditor on November 26th. A review of this information resulted in the auditor completing an issue log containing questions and requests for clarification and additional information. The issue log was completed and returned with the requested additional information within a week.

On January 6th, documents were emailed to the PREA Coordinator and Compliance Manager requesting that they complete the tables listing staff members and youth in the required categories to assist the auditor in selecting staff and youth for specialized interviews. From these lists the auditor randomly selected 19 staff members representing each of the specialized designations, a contractor, and a volunteer to be interviewed.

The staff categories included staff members with the following designations:

- Superintendent
- Compliance Manager/Coordinator
- Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment
- Medical staff
- Mental health staff
- Non-Medical staff involved in cross-gender strip or visual searches
- Administrative (Human Resources) staff
- Volunteers who have contact with residents
- Contractors who have contact with residents
- Investigative staff
- Staff who perform screening for risk of victimization and abusiveness
- Staff on the sexual abuse incident review team
- Designated staff member charged with monitoring retaliation
- First responders-both security and non-security staff
- Intake Staff

One of the other documents was organized into categories that required the facility Compliance Manager to provide names of the youth who are part of the National PREA Resource Center's prescribed targeted populations as follows:

- Youth with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
- Youth who are Limited English Proficient (LEP)
- Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) youth
- Youth who reported sexual abuse

- Youth who reported sexual victimization during risk screening
- Youth in isolation

Eleven youth were selected for interviews and represented youth from each targeted category required for specialized interviews. Further details are included below in the On-site Audit section.

A list of the selected youth, staff members, volunteers, and a contractor to be interviewed was sent via email to the PREA Compliance Manager two workdays before the on-site portion of the audit to allow time to make arrangements for coverage during interviews.

Prior to the audit, the auditor reviewed the MOU between the JCC – St. Anthony facility and the Family Crisis Center located in Rexburg, Idaho and interviewed the Executive Director of the crisis center. The Executive Director stated that the MOU was in place and the following services would be provided when needed:

- Accompany youth to the examination and during investigation
- Advocacy services through the hotline
- Twenty-four on-call staff
- Counseling services

During the pre-audit phase the auditor also contacted Just Detention International (JDI) through email and inquired as to whether or not their organization had received any complaints about the JCC-St. Anthony facility in the 36 month period prior to the audit. JDI responded to the inquiry within 24 hours, stating that they had not received any complaints about the JCC-St. Anthony facility.

No external investigators were used to conduct administrative investigations. Administrative investigations at JCC-St. Anthony are conducted by facility employees who have received specialized training as required in standard 115.334. Criminal investigations at the facility are conducted by the Fremont County Sheriff's Office. Criminal and administrative investigations are discussed in detail under their specific standards later in the report.

An internet search of the JCC St. Anthony facility was conducted in the pre-audit phase and yielded several IDJC links to information about the St. Anthony facility. The search also brought up a newspaper article covering a December 2019 *Bureau of Justice Statistics* report titled *Sexual Victimization Reported by Youth in Juvenile Facilities, 2018*. In this report JCC-St. Anthony was listed as one of 12 facilities identified as having a high rate of sexual victimization. The PREA Coordinator was forthcoming with this report and had provided the auditor with this report soon after its release along with the IDJC response. The IDJC response detailed that in 2018 the JCC-St. Anthony facility held 218 juveniles and during that time there were 24 reports received. Of those reports 4 were substantiated incidents, 1 was an unsubstantiated incident, 3 were unfounded incidents, 6 were investigated and ruled out (non-PREA), and 7 incidents reported were determined to constitute non-abusive contact.

The auditor also reviewed the IDJC website during the pre-audit phase. The agency website includes the following PREA-related information. Each item is discussed in detail in the corresponding standards.

- Policy governing sexual abuse/harassment
- Information on how to report alleged abuse or sexual harassment on behalf of a youth
- Contact information for IDJC and Child Protection to report sexual abuse or harassment
- Aggregated sexual abuse data from IDJC-operated facilities
- Historical sexual abuse data

- Past PREA reports for each of the 3 state operated facilities
- A Frequently Asked Questions section
- An English and Spanish juvenile PREA education video

On-site Audit

Upon arriving to the facility, the auditor met with the facility Superintendent Skip Greene, Program Manager Beverly Wilder, PREA Compliance Manager Katie Withers, and PREA Coordinator Joe Blume. The introduction meeting included discussion regarding the schedule for the week, the facility inspection, the number of interviews that would be taking place, the expectations for determining compliance, the process following the completion of the on-site audit. It was also verified that counselors would be available if needed for anyone who participated in an audit interview. Following the introduction the auditor completed a tour of the facility. During the inspection the auditor observed the 27 buildings on the campus including the six cottages where the youth reside. Four of the cottages are an open, dormitory style format, and two cottages, Yellowstone and Owyhee, are single cell format. Other areas inspected included the administration offices, interior and exterior mechanical and storage closets, the academic building, the clinic, the cafeteria, the chapel, the gym, the laundry building, the blacksmith and carpenter shops, the storeroom, and the carriage house and maintenance building. During the inspection, consideration was given to camera placements and potential blind spots, the configuration of the dorms, restroom and shower areas, programming activities and educational programs, the level of youth supervision, areas lacking sufficient monitoring, and PREA notifications and posters. Additional cameras and security mirrors added since the previous audit to enhance surveillance and reduce blind spots were discussed and noted during the tour. PREA related updates noted during the tour and during the course of the audit include:

- Upgraded cameras with wider angles and higher resolution
- Added camera to the food service area and side room
- Added a ball mirror to the side room in food service
- Added cameras to the laundry building, the clinic, and the assessment building conference room
- Added an additional server
- Added a video monitor to the staff observation area on Bitterroot cottage
- Removed bunkbeds to allow a better line of sight and increased the space between beds in Bitterroot cottage
- Added magnetic covers to the windows in Owyhee cottage so they can be used when youth are changing clothes
- Added security mirrors by the restrooms in all the dorms to allow better supervision from the staff booth on the night shift. You can't see the youth using the restroom but you can see that there is only one youth in the restroom.
- Modified the restroom doors in Bitterroot cottage to half doors
- Unit Managers now have access to review their cottage videos
- A ball mirror was added in the hallway in Targhee cottage and dividers were added to their showers.
- Mirror tinting was added to the staff booth in Yellowstone cottage to ensure you can't see into the showers from the Huskies group dayroom. This eliminated the need to use blinds which increases the staffs' line of site.
- Cameras are being added to the facility's transport bus.

Grievance forms were available in each cottage, which was confirmed during informal interviews with random youth and through observation and discussion with cottage staff during the facility inspection. Each of the randomly selected youth interviewed during the on-site audit was able to describe the process of filing a PREA related grievance if needed. The youth complete the grievance then place the form in an envelope and check the PREA box on the envelope before placing it in a locked box on the cottage. Security personnel check each grievance box on the campus every evening while making their rounds. Any grievance checked PREA are opened and read to the PREA Compliance Manager over the phone. The PREA Compliance Manager then makes a decision as to what steps need to be taken to address the grievance and the urgency of the matter dictates if she returns to the campus immediately or begins the investigation the next day.

Processes observed during the facility tour and during the course of the on-site portion included medication being dispensed, movement across campus to and from school, youth interacting with each other and staff on the cottages, classes taking place in the school, and a youth intake. During each activity, staff members were positioned so that line of sight and overall safety was maintained. Positive staff rapport with the youth was evident throughout the audit.

Following the facility tour, staff and youth rosters were provided for the auditor to select random staff and youth for interviews. The auditor followed the criteria provided in the PREA Auditor Handbook in determining the number youth to interview and to ensure that all the targeted populations were included in the selection process. Interview rosters were finalized first thing on the beginning of the second day of the audit. The auditor selected Rehabilitation Technicians from each shift and ensured that staff from every cottage were included in the interviews. The auditor selected medical and mental health care staff, agency and facility department heads, contracted services director, and youth from all cottages representing each category of the PREA Resource Center's (PRC's) targeted populations. Interviews took place in the conference room of the Sawtooth/Assessment Building. The SAFE/SANE nurse and director of the Family Crisis Center were interviewed by telephone prior to the on-site audit to discuss the agreements in place with the facility to ensure access to services. A volunteer and a contractor were interviewed on site to discuss the PREA training they received. The Executive Director and Contract Administrator for the IDJC were interviewed by telephone during the on-site portion of the audit as they are located in the agency headquarters in Boise, Idaho. Formal interviews commenced during the morning of the second day of the audit and were completed just before lunch on the fourth and final day of the audit.

The auditor used the National PREA Resource Center's Interview Protocols for Juvenile Facilities for guidelines and interview questions. Responses to questions regarding staff members' knowledge of PREA policies, reporting responsibilities, first responder and investigative duties, and training were compiled and given consideration when determining PREA compliance. Youths' responses to questions regarding their knowledge of PREA policies, the education and services they receive, and intake processes were also essential in determining compliance. During interviews, a mental health professional was available to provide services should youth need assistance after an interview, but no youth required or requested this service.

Interview totals were as follows:

Interviewees	Total Interviewed
Random staff	16

Specialized staff	16
Volunteers and contractors	2
Random youth	14
Disabled Youth	N/A
Youth with limited English proficiency	1
Youth who identify as LGBT	2
Youth who reported a sexual abuse	4
Youth placed in isolation	N/A
Youth who disclosed prior sexual victimization during risk screening	5

In addition to completing interviews, the fourth and final day of the on-site portion involved reviewing additional documentation requested by the auditor and provided by the Compliance Manager and PREA Coordinator. The records of 5 randomly selected youth were reviewed to determine compliance with intake procedures, PREA comprehensive education, and disclosures of prior victimization. Personnel files were provided during the on-site audit of random staff members, two staff members who were recently promoted, and one contractor were reviewed to determine compliance with criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings. Personnel files are discussed below in Standard 115.317. The Compliance Manager also provided the auditor access to all PREA investigation cases completed since the previous audit. The auditor selected three cases and reviewed the information on the Compliance Managers computer. The auditor also met with the intake supervisor who demonstrated the intake process and provided intake documentation for the auditor's review.

Additional documentation reviewed prior to and during the audit included the following. Each item is discussed below within the relevant standards.

- Organization charts
- Contracts for the confinement and care of IDJC youth
- JCC – St Anthony Staffing Plans
- Duty Officer Reports/Unannounced Rounds
- Safe housing assessments and reassessments
- PREA education materials
- Notifications made to youth following an investigation
- Sexual Abuse Incident Review Form
- Facility map with buildings and camera numbers

- Facility schematics with camera placements
- Investigative reports
- Training curricula
- Investigative reports
- Youth grievances
- Data collection instrument
- Retaliation Monitoring forms
- Nursing protocols
- Various email chains demonstrating discussions regarding PREA topics

Around noon on the fourth day the auditor conducted a brief exit meeting with the Superintendent, the Program Manager, the Compliance Coordinator, and Compliance Manager. The meeting was used to briefly discuss the facility's overall compliance, staff and youth knowledge regarding PREA, and what to expect following the on-site portion of the audit.

Post On-Site Audit

Following the audit, the auditor compiled facility inspection, formal and informal interview information, and documentation data gathered in the pre-audit and on-site audit phases. Numerous follow-up communications via email, text messages and telephone calls between the auditor, and the PREA Coordinator took place during the post audit phase. Several additional pieces of information were requested by the auditor and all additional documentation was promptly provided by the PREA Coordinator and the Compliance Manager. The final bit of requested information was received during the first week of May and the interim PREA Audit Report indicating the compliance determinations for each standard was sent via email to the PREA Compliance Coordinator on May 14, 2020. On June 26, 2020 the PREA Compliance Coordinator provided the auditor with the IDJC's response to the interim report. The response, detailed in full under standard 115.313, describes the agency's plan of action to improve the JCC-St. Anthony facility's ability to meet the required staffing ratio to become fully PREA compliant on future audits. The final PREA Audit Report was issued on June 30, 2020.

Facility Characteristics

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

The JCC – St. Anthony facility is the largest and oldest of three high-restriction facilities operated by the Idaho Department of Juvenile Corrections. The facility sits on about 20 acres of land one mile west of the city of St. Anthony, the county seat of Fremont County, Idaho. JCC-St. Anthony serves adolescent male and female offenders between the ages of 13 and 21 years old. The facility is over 100 years old and has a designated capacity of 128 youth. The facility had a population of 105 youth on the first day of the audit. The average length of stay for youth at the facility is 16.7 months.

The facility is well maintained and has 27 buildings located on the property including six housing units referred to as cottages. Four of the cottages are multiple occupancy housing units and the other two are single cell design with a total of 44 rooms. Other buildings on the campus include education and vocational training buildings, a food service building that also houses the gym, a chapel, an administration building, an assessment center where interviews for the audit were conducted, a chapel, a laundry building, a maintenance building, a carpenter shop and a blacksmith shop. Several older buildings like the dairy building are used by maintenance to store equipment and supplies. There is also an outdoor basketball court, a large soccer field, a softball field, and a challenge course with high and low elements. Each of the 6 living units has one Unit Manager, two Group Leaders, one Clinician, and a number of direct care staff referred to as Rehabilitation Technicians. The number of Rehabilitation Technicians varies by cottage. One of the cottages, Caribou, had disbanded one of the groups prior to this audit due to lower population numbers at the facility. This allowed the facility to utilize the staff to increase coverage in other cottages. The facility is not mandated, at this time, by state law, to comply with specific staffing ratios. The facility works towards maintaining the recommended staffing guidelines described in the Idaho Administrative Procedures Act (IDAPA). The facility also develops an annual detailed staffing plan that describes the staffing needs and digital surveillance required to ensure the ongoing safe operations of the facility. In order to become fully PREA compliant the facility would have to meet the mandated staffing ratios of 1 to 8 during waking hours and 1 to 16 during sleeping hours that went into effect in October of 2017. Based on a review of documentation provided, interviews with staff, and observations made during the audit, the facility is able to maintain the mandated ratios at times, but additional staff are required to become fully compliant with PREA standards.

The total number of staff having contact with the youth was 168 as of November 2019. The total number of volunteers and contractors authorized to enter the facility at the time of the audit was 67, with all but 8 being volunteers.

Although there is not a secure fence surrounding the facility, traffic into and out of the facility is controlled with an electronic gate requiring a code after hours.

Programming at JCC-St. Anthony continues to be built on Positive Peer Culture (PPC). PPC is a system for developing positive youth subcultures to the degree that a therapeutic process becomes woven into the youth's daily experience and therefore the youth never exits the

therapeutic process. PPC is a strength based peer helping model that fosters active caring and teaches youth that investing in others is fashionable. The PPC model has been the foundational program at JCC-St. Anthony for more than 30 years. The staff and youth were able to discuss the PPC program at length. As part of the PPC program the facility also provides the following treatment components:

- Male Conduct Disorder/Substance Abuse treatment
- Female Conduct Disorder/Substance Abuse treatment
- Juvenile sex abuse treatment

Youth receive on-site education services through the IDJC, which operates as an independent school district. Youth may earn their diploma or high school equivalency certification while also participating in vocational training. Teachers were present in each classroom and are fully trained as rehabilitation technicians and count in the staffing ratio. Education staff are responsible for the direct supervision of the youth from 7:45AM to 2:30PM during the week. Security staff are available to assist during the school day if necessary.

Medical services are provided at the on-site clinic which is staffed by licensed nurses from 6AM-10PM 7 days per week. There is an on call nurse after hours at all time. The clinic is supervised by a Registered nurse. The facility contracts with a doctor who makes weekly visits to the facility and a Psychiatrist who comes to the campus twice a month. If medical needs cannot be addressed on site youth are taken to Madison Memorial Hospital in nearby Rexburg, Idaho. Sexual assault forensic medical exams would take place at Madison Memorial Hospital.

The facility has an extensive surveillance system consisting of 139 cameras placed throughout the campus. The facility has upgraded their surveillance by adding additional cameras, and security mirrors and upgrading their servers which is discussed later in the report. Cameras can be reviewed from the office of the Superintendent, the Program Manager, or the Safety and Security Supervisor. The auditor reviewed cameras with the Superintendent and the Safety and Security Supervisor during the audit. Cameras were pulled up on request and none that were reviewed were positioned where the youth's restroom or shower areas were visible in the cameras range.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 4

List of Standards Exceeded: 115.333, 115.352, 115.363, 115.373

Standards Met

Number of Standards Met: 36

Standards Not Met

Number of Standards Not Met: 1

List of Standards Not Met: 115.313

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. PowerPoint presentation: PREA Basics for Juveniles
4. IDJC organizational charts
5. IDJC PREA Incident Review form

Interviews:

1. PREA Compliance Coordinator
2. PREA Compliance Manager

Observations: No observations relative to this standard are required.

(a): IDJC has a written policy stating that all forms of sexual abuse and harassment are prohibited and stipulates that IDJC “facilities and contract providers will adhere to a zero tolerance standard for incidences of sexual abuse or misconduct.” The policy includes details regarding how the policy will be implemented in order to prevent, detect, and respond to sexual abuse or harassment. This policy contains a glossary of terms and acronyms. Additional terms and definitions are included in the PowerPoint presentation used for resident training, and the IDJC PREA Incident Review form contains categories and corresponding definitions of sexual conduct. Regarding potential sanctions, the policy states that termination is the presumptive disciplinary action for staff who have engaged in sexual abuse, and the PowerPoint informs residents that sanctions including possible criminal charges could be imposed for residents engaging in sexual abuse or harassment.

(b): The IDJC has a designated agency-wide PREA Compliance Coordinator as well as a facility-level PREA Compliance Managers. The St. Anthony organizational chart includes the name of the facility Compliance Manager, and the Quality Improvement Organizational Chart includes the name of the agency-wide Compliance Coordinator who supervises three Compliance Managers. During his interview, the Compliance Coordinator stated he had sufficient time to perform his duties regarding compliance with the PREA standards. He said he supervises three Compliance Managers, identifies issues, maintains contact with the Managers, works with the Managers as they navigate cases, offers guidance and support, completes reports, and works with the Managers on the annual reports required by the agency.

(c): St. Anthony employs a Compliance Manager who reports to the agency-level Compliance Coordinator as evidenced by the organizational chart. During her interview, the Compliance Manager said she had sufficient time to preform her duties relating to the prevention of sexual abuse and harassment and stated St. Anthony is supportive of providing sexual safety at the facility.

Summary of Findings:

The auditor reviewed the IDJC's PREA Policy and evaluated the document against the requirements of this standard and the PREA Audit Tool, which stipulate: the policy must a) be written, b) mandate zero tolerance, and c) mandate the designation of agency-wide Compliance Coordinator and facility-level Compliance Managers. The agency's written PREA policy contains each of these three requirements, which supported compliance with provision (a). The organizational charts include the Compliance Manager and Compliance Coordinator positions as required by the facility policy and provisions (b) and (c), which supports compliance with these provisions. During interviews, the Compliance Manager stated she had sufficient time to perform her PREA-related duties outlined in provisions (b) and (c). The Compliance Coordinator stated he has sufficient time and authority to be effective in his role as provisions (b) and (c) require. Based on the documents reviewed and interview responses, the auditor determined the facility satisfied each element in the Audit Tool, demonstrated compliance with all provisions, and thus meets the requirements of this standard.

Corrective Action: None

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Contracts for the confinement of residents

Interviews:

1. Contract Administrator/Purchasing Agent

Observations: No observations relative to this standard are required.

(a): The PAQ indicated IDJC has entered into contracts for the confinement of residents since the previous audit. Five contracts were provided and reviewed. Four contracts indicate the contractor must adopt and comply with the PREA standards, agree to IDCJ conducting announced or unannounced compliance monitoring, and is subject to a PREA audit every three years. The fifth contract requires the contractor to have a written plan for preventing, detecting, and responding to allegations and/or incidents of sexual assault or misconduct pursuant to the PREA. The contract also states that the plan must be submitted to the Department, report any PREA-related incidents to the Department, provide resident victims with medical and mental health care, and cooperate with investigations of sexual assault of misconduct. The PAQ indicates IDJC has entered into 99 contracts since the last PREA audit.

(b): The PAQ indicates all contracts require the agency to monitor the contractor's compliance with the PREA Standards. During his interview, the Contract Administrator said a section is written into each contract requiring the Quality Assurance to monitor the facility for PREA compliance. He said the QA provides details of the monitoring visit in annual report, which informs the facility that the facility is eligible for renewal. He stated contacted facilities are required to maintain PREA compliance and must post their audit results or otherwise make them available to the public. The sample contacts and contract language provided indicate programs must comply with the PREA.

Summary of Findings:

Standard 115.312 stipulates a) the contract must require compliance with the PREA Standards and b) the contract must provide for monitoring of the contractor. To determine compliance with this standard the auditor reviewed the language of five contracts provided for the audit, and evaluated the language against the requirements of the standard and the PREA Audit Tool. Four of the contracts include language supporting compliance with provisions (a) and (b). The interview with the Contract Administrator provided additional evidence of compliance with both provisions, as he stated all contractors are required to comply with the PREA and agree to IDJC compliance monitoring. Sample contracts were provided that contained language requiring IDJC to monitor the facility for compliance with the PREA, which provided the auditor with sufficient evidence of compliance with provision (b).

Because compliance was demonstrated with provisions (a) and (b), the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.313: Supervision and monitoring

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

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
 Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? Yes No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? Yes No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? Yes No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) Yes No NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
 Yes No NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) Yes No NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) Yes No NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) Yes No NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? Yes No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? Yes No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) Yes No NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) Yes No NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. JCC-St. Anthony Staffing Plans for 2017, 2018, and 2019
3. Staffing plan development emails
4. Deviations from staffing plan
5. Internal Staffing Assessment for JCC-St. Anthony
6. IDJC Policy 621 – Duty Officer Responsibilities
7. Duty Officer reports for 12 months preceding the audit with unannounced rounds reports and observations

Interviews:

1. Facility Superintendent
2. Compliance Manager
3. Compliance Coordinator
4. Staff responsible for conducting unannounced rounds

Observations:

1. Camera placement
2. Video surveillance system
3. Staffing levels during facility inspection

(a): The IDJC requires that each facility develop a written staffing plan that considers staffing levels and patterns, video monitoring, and documents deviations from the plan. The Superintendent, or designee, must approve the plan for each cottage with consideration given to each element for provision (a) of this standard. Both the Superintendent and Compliance Manager stated during their interviews that each item in this provision is considered when updating the facility staffing plan. The Superintendent stated that the staffing plan development is an on-going process that is frequently reviewed and discussed in the morning leadership team meetings. The Compliance Manager stated in her interview that every year she communicates with each Unit Manager who sends her a written update with any changes that have occurred in the plan for their cottage since the previous staffing plan was approved. This includes changes in the population capacity, the type of youth offender, the lay-out of the cottage, changes in programming, or steps that have been taken to address blind spots. The master plan is then updated and discussed with the Superintendent. The Superintendent stated in his interview that the Compliance Manager is very involved in the development process each year. The current staffing plan included supervisory signatures and dates for the Unit Managers for each cottage plan, the Education Supervisor for the education section, the Safety and Security Supervisor for the Safety and Security Officers section, the Laundry Supervisor for the laundry services section, and the Food Services Supervisor for the food services section. The final staffing plan was then signed signifying approval by the Superintendent, the PREA Compliance Manager, the JCC-St. Anthony Program Manager and the Clinical Supervisor in August of 2019. This signifies input from many leadership positions on the campus in the development of the annual staffing plan. The staffing plan includes the eleven provisions described in subsection (a) of the standard. The staffing plan and the PAQ both list the number of residents the plan was predicated on as 140. The staffing plan also includes schematics, including camera placements, of each cottage, the education building, the food service and

laundry building, and the facility clinic. The plan also includes a master staffing schedule for each building and the shift times for each building. The staffing plan for each cottage lists any identified blind spots, a description of the youth population, and a description of the programming that takes place in each of the units. A listing of the number of cameras in each building is provided along with a schematic of the campus.

(b): The PAQ stated that the facility documents each time there is a deviation from the staffing plan. The six most common reasons for deviations provided on the PAQ include vacation coverage, sick/illness coverage, transports, training coverage, emergency medical coverage, coverage of high level suicide watch. A month of staff scheduling was provided for each cottage for the auditor to review. Each schedule provided did include notations when staff called in sick, left early, or were required to go on transport. The Superintendent stated in his interview that provisions were in place to ensure that the staffing needs at the facility are met, although PREA required staffing ratios are not always met. After reviewing the documents provided, the auditor believes that the JCC-St. Anthony facility schedules their staff within the guidelines outlined in their staffing plan. The schedules provided for review also demonstrated that deviations are documented as required to show compliance with the standard. It is noted that The JCC-St. Anthony staffing plan is not created with the number of staff to allow the facility to meet the mandated ratios discussed in provision(c) to demonstrate full compliance with this standard.

(c): JCC-St. Anthony is not able at the time of this audit to staff the facility at the required 1:8 and 1:16 level to show compliance with this provision of 115.313 standard. This was acknowledged in the PAQ, the facility's staffing plan, and the formal interviews conducted during the on-site audit. Outside of the PREA standard that took effect October 1, 2017 the facility is not required by any other state law, regulation, or judicial decree to maintain the PREA required staffing ratio. The facility's staffing plan shows that 4 of the 6 cottages are out of compliance with the PREA required staffing ratios on the overnight shift. Four of the cottages have one staff working the overnight shift, with the two staff scheduled each night on the sex offender dorms. The Superintendent stated that the supervisors and staff are aware of staffing needs and the facility adheres to their policies and procedures. Staff are called in as needed to provide coverage and staff are required to stay over if necessary until they are relieved to go home. The auditor requested to review an internal staffing assessment that was conducted in September of 2019 concluded the facility would require an additional 32 staff to meet the PREA required ratios. An additional assessment was scheduled to be conducted by an outside analyst to study staffing levels and make recommendations to enhance coverage with the current number of staff following the audit. This study is being rescheduled due to the COVID 19 pandemic until a later date. It is important to note that staff morale was high during interviews and during informal interactions. The staffing levels on the JCC-St Anthony campus are not within the PREA mandated guidelines but operations on the campus remain the same as they have for years prior to and after the October 1, 2017 date. The auditor never sensed that there was a lack of supervision and the campus administration has continued to take steps to enhance the safety of the youth and staff by increasing the video surveillance, reducing blind spots, and providing quality training to their staff.

(d): The 2019 JCC-St. Anthony staffing plan was reviewed and compared to the previous staffing plans provided by the facility and each includes updated procedures, reviews, revisions to the schedules and current population, procedures regarding room and dorm assignments, PREA supervision requirements, and any changes to floor plans and camera totals. Revisions in the plans are easily found as camera totals have changed in several of the dorms and descriptions of the programming and population on the dorms are revised and blind spots are eliminated as the plans are updated. Emails provided to the auditor between the PREA Coordinator and the Compliance Manager demonstrated the ongoing annual process as

discussion involved timelines and reminders on updating the plan.

(e): IDJC policy requires managerial staff or administrative staff members designated by the Superintendent to serve as duty officer (DO) to conduct and document unannounced rounds at least twice during their week long rotation on duty. Policy requires that the unannounced rounds occur on day and night shifts. Supervisory staff responsible for conducting unannounced rounds said during interviews verified that they are required to do so at varied times, they must document their findings on the Supervisor Unannounced Rounds form, and are discouraged from alerting other staff that unannounced visits are occurring. The Unannounced Rounds form is turned in with the weekly DO report at the conclusion of the 7 day rotation. The auditor reviewed many of the weekly DO reports that were provided for a 12 month period which demonstrated the unannounced rounds were conducted and required the DO to make a number of checks such as verifying groups are in the appropriate locations based on schedules, checking blind spots, staffing requirements are correct, staff positioning is appropriate and staff are actively supervising the youth. The DO's name, the date of the rounds, the time the rounds started and ended, and observations were included on each report.

Summary of Findings:

The auditor reviewed IDJC Policy, staffing plans, staff schedules, the PAQ, and Duty Officer Unannounced Supervisor Rounds forms. These documents were assessed against the requirements of this standard and the PREA Audit Tool, which require: a) the development and implementation of a staffing plan that provides adequate staffing levels and the determination of the need for video monitoring; b) compliance with the plan and documentation of deviations; c) maintaining PREA-required staffing ratios; d) at least annual assessments of the staffing plan, staffing patterns, video monitoring systems, and available resources; and e) conducting and documenting unannounced rounds.

The JCC-St, Anthony facility staffing plan and development process includes all elements of provision (a). The emails provided to the auditor along with the signatures and dates from the Unit Managers from each cottage, the Safety and Security Supervisor, the Laundry Manager, and Food Services Manager on their sections of the plan demonstrates their input and compliance with provisions (a) and (d) of the standard. Interviews with the Superintendent and Compliance Manager also support compliance with provisions (a) and (b) as both parties were able to describe the staffing plan review process and communicated knowledge of the items in provision (a), and both reported that the facility had not deviated from the plan which demonstrated compliance with provision (b).

To demonstrate compliance with provision (c), the JCC-St. Anthony facility must demonstrate that the facility maintains staffing ratios of a minimum of 1:8 during waking hours and 1:16 during sleeping hours except during limited or exigent circumstances, and any deviations shall be documented. After reviewing the documentation provided and considering information gathered during interviews the auditor determined that compliance could not be demonstrated with provision (c) of the standard. The facility has not been approved for the funding necessary to add the additional staff to meet the required ratios to demonstrate compliance with this provision.

Compliance with provision (e) of the standard was demonstrated through the review of IDJC policy and 12 months of DO reports which include unannounced rounds. The reports

demonstrate that the rounds occur twice weekly and cover both AM and PM shifts. This practice was verified through interviews with staff who conduct the rounds while serving as the Duty Officer.

Based on the documentation reviewed, the interview responses, and observations made during the on-site portion of the audit, the auditor determined that the facility demonstrates compliance with all but one provision in the standard. Because the facility does not maintain the staff-to-youth ratios of required by provision (c) of this standard, it has been determined that the facility is not in compliance with this standard and corrective action is necessary.

Corrective Action:

1. Provide evidence that the JCC-St. Anthony facility is able to implement and maintain the required staff ration of 1:8 during waking hours and 1:16 during sleeping hours.

Corrective Actions Taken since the Interim Audit Report:

The PREA Coordinator provided information in an email sent on June 26, 2020 regarding the plan in place to improve the agency's ability to meet the prescribed 1:8 staff to resident ratio during waking hours and 1:16 staff to resident ratio during sleeping hours. This plan includes the following steps, in blue text.

1. The Idaho Department of Juvenile Corrections (IDJC) is currently making great strides towards its mission of developing productive citizens in active partnership with communities. This effort has resulted in new record low populations of juveniles committed to IDJC.
2. The Juvenile Placement Manager shall continue to collaborate with agency & facility leadership to monitor and assess juvenile population trends and levels at each IDJC-operated facility to ensure that resident population levels are effectively kept within the ranges prescribed in each facility's Staffing Plan.
3. As resident population continues its downward trend, IDJC will continue to respond by decreasing the average therapeutic group size, and/or eliminating groups in order to redistribute staff as we are able to do so.
4. Assessment of staffing levels will be independently verified via contracted services to identify any gaps in compliance with the mandated ratio, considering the following criteria:
 - a. Assessment of ratio based on current staffing level and current resident population,
 - b. Assessment of ratio based on current staffing level and a prescribed (operational) resident population, and
 - c. Assessment of ratio based on current staffing level and available bed space.
5. All Peace Officer Standards and Training (POST) certified staff will be included in the

calculation of staffing ratios.

6. IDJC is participating in a national “Length of Stay Academy” in order to research best practice and evidence based strategies to overall reduce the length of stay for most juveniles committed to IDJC custody.

The FAQ dated June 9, 2013 from the PREA Resource Center (PRC) states that “*Other persons whose duties involve supervision and control of residents for a portion of the day may count towards these ratios while they are actively supervising and controlling residents, assuming that they have received appropriate training.*”

Please note that IDJC’s training requirements mandate that all staff members who are POST certified, receive the same level of safety and security training as direct care staff, which allows IDJC to utilize POST-certified staff members in addition to direct care staff (Rehabilitation Technicians, Safety and Security Officers and Instructors), to meet the required PREA ratios. Staff members meeting this criteria include Instructor Assistants, Rehabilitation Technician Supervisors, Rehabilitation Specialists, Rehabilitation Specialist Associates, Safety and Security Supervisors, Recreation Coordinators, and Clinicians.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? Yes No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) Yes No NA

115.315 (e)

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

115.315 (f)

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

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 620 – Contraband Detection and Disposition/Searches
3. IDJC Policy 672 – Non-discrimination of Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning Juveniles
4. IDJC Policy 608 – Juvenile Supervision
5. PowerPoint presentation – Supervision and Management of LGBTI Youth
6. PowerPoint presentation – Mechanical Restraints Final

Interviews:

1. Random residents
2. Transgender residents

Observations:

1. Individual rooms
2. Showers and bathrooms in all dorms
3. Shower routine in two dorms

(a): IDJC policy states that “pat-down searches of individual juveniles must be conducted only by staff of the same sex as the juvenile and must be witnessed by another staff or done in view of a camera.” Policy stipulates, “Manual or instrument body cavity searches for contraband are not performed by IDJC staff under any circumstances.” The PAQ indicates there have been zero cross-gender strip or cross-gender visual body cavity searches of residents in the previous 12 months. No interviews were conducted with a non-medical staff member involved in a cross-gender search, because the facility prohibits these types of searches. Similarly, no logs of cross-gender searches could be reviewed, as these searches are not conducted.

(b): IDJC policy prohibits cross-gender pat-down searches under any circumstances. During interviews, all residents reported being pat searched by a same-gender staff member, and none reported being searched by a cross-gender staff member. Staff members said cross-gender searches are not allowed under any circumstances and that same-gender staff members are always available to conduct searches per IDJC policy. The procedure for conducting pat searches is included in the PowerPoint presentation: Mechanical Restraints Final.

The policy pertaining to residents who identify as LGBTIQ states that searches of these “juveniles are performed in accordance with Contraband Detection and Disposition/Searches (620) policy /procedure.” The policy also stipulates, “A transgender juvenile may request that male or female staff conduct the search and the request is accommodated, whenever possible, considering staffing and safety needs.”

(c): IDJC policy prohibits cross-gender pat-down searches; thus, no cross-gender pat-down searches were conducted or documented.

(d): IDJC policy pertaining to the supervision of juveniles states that “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. Staff members and residents reported the practice of announcing opposite-gender staff members is consistently followed, and the auditor observed this procedure on several occasions during the facility tour.

During interviews, staff and residents reported that residents were able to undress, shower, and use the bathroom out of view of all staff members including those of the opposite gender and all other youth. Cameras were viewed in several dorms to ensure the shower and bathroom areas allowed youth privacy. The Safety and Security Director also pulled up numerous cameras from his computer in the Administration Building to verify that the cameras do not violate the youths’ privacy.

(e): IDJC policy stipulates, “The facility shall not search or physically examine any juvenile for the sole purpose of determining the juvenile’s genital status.” Staff members communicated an understanding of the policy during interviews. The two transgender residents said searches are conducted by male staff in a respectful manner and neither had requested that their searches be conducted by female staff.

(f): The PAQ indicates 100% of security staff received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents. The PowerPoint presentation regarding LGBTIQ residents includes slides stating that staff members will “refrain from making statements that imply or directly state LGBTI juveniles are abnormal, deviant or sinful, or that they can or should change their sexual orientation or gender identity.” A second slide directs staff members to avoid language such as choice or sexual preferences when referring to gender identity or sexual orientation and to refrain from discussing religious ideology relating to LGBTI topics. Training logs were reviewed and indicate staff members have received this training.

Summary of Findings:

The auditor reviewed policy and training curricula regarding strip, body cavity, and cross-gender searches and compared these documents against the details of this standard and the PREA Audit Tool, which: a) prohibits cross-gender strip and body cavity searches; b) prohibits cross-gender pat searches except during an exigent circumstance; c) requires documentation and justification of cross-gender visual body cavity searches and cross-gender pat searches; d) requires policy and procedures that ensure residents’ privacy while showering, changing clothes, and performing other bodily

functions; requires staff members of the opposite gender to announce their presence; e) prohibits examining a transgender or intersex youth to determine genital status; and f) requires training regarding searches.

Evidence of compliance includes agency policy and training materials that align with provisions (a) – (f). Compliance with provision (b) was demonstrated as staff members stated cross-gender searches were prohibited. Compliance with provision (d) was determined because: 1) opposite-gender staff members were following policy by announcing their presence when entering dorms, 2) staff and residents reported this was the expected practice during interviews, and 3) facility bathrooms, showers, and rooms were observed to provide adequate privacy to youth when changing clothes, showering, and performing bodily functions. The auditor determined the facility meets the requirements of provisions (a) - (e) after reviewing policy, making observations, and interviewing staff members and youth; and thus, meets the requirements of this standard. While not a violation of PREA standards, it is noted that shower poles are still used in two of the dorms as discussed in the previous audit report. Staff are strategically positioned during the shower routines to limit the invasiveness while still ensuring safety, but the setup allows minimal privacy for the youth.

Corrective Action: None

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

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

115.316 (a)

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.316 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 640 – Observation and Intake
3. Invoices for language interpreting service

Interviews:

1. Resident with intellectual disability
2. Residents with limited English proficiency
3. Staff members who provide PREA training to youth

Observations:

1. Interactions between staff members and residents
2. PREA posters in English and Spanish

(a): IDJC has taken steps to ensure youth with disabilities have equal opportunity to participate in and benefit from IDJC's efforts to prevent, detect, and respond to sexual abuse. Policy requires intake staff members to read and explain the intake forms if the resident is unable or unwilling to do so himself. In these cases, the intake staff member emails the Clinical Supervisor and education staff to inform them they observed possible disabilities. Policy also requires that juveniles be provided the necessary information and documents, including explanation and clarification by staff as needed. The PowerPoint used in training staff members contains a slide regarding vulnerable youth including residents with limited English or physical or mental disabilities and LGBTI youth. The notes section includes speaking points addressing the importance of ensuring these youth understand the PREA. In the Issues Log, the PREA Compliance Coordinator wrote, "Depending on the disability IDJC would make accommodations accordingly. JCC-St. Anthony has several juveniles who are cognitively delayed & when the training is taught to them those Group Leaders make sure that they are going at a pace that the juvenile understands. Any juveniles that are a behavioral health referral are identified at the front end & the Group Leader knows what accommodations need to be made."

During interviews, residents with disabilities and limited English stated they received PREA-related information during intake and periodically during their stay. One stated she received the information with the assistance of a tutor and reported receiving additional help through special educating services in school. She said the special education teacher was the staff member who provided her information about PREA.

(b): IDJC has taken steps to ensure residents who are limited English proficient have equal opportunity to participate and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse. Written materials and PREA-related posters are presented in English and Spanish. Additionally, the facility has contracted with a language line and translation services. The invoice for the language line was uploaded for review and indicated the line was utilized by the facility. A referral for external clinical services was uploaded and indicated a non-English speaking resident was referred for interpreter services. A second document indicated the services of an Arabic interpreter were used with a resident placed at St. Anthony. As noted above, residents with limited English reported receiving information about PREA in a way they understood.

(c): IDJC policy prohibits the use of "juvenile interpreters, juvenile readers, or other types of juvenile assistants to facilitate the intake process except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the safety of the juvenile(s) and staff." The PAQ indicates there have been zero instances of using residents to interpret for another resident in the last 12 months. During interviews, staff members stated resident interpreters would not be used and said they had not seen this happen during the course of their employment.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require: a) youth with disabilities have equal opportunity to participate or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and harassment; b) youth who are limited English proficient have meaningful access to these efforts; and c) resident interpreters will not be used except in limited circumstances. The auditor determined IDJC policy addresses each of these requirements, which support compliance with provisions (a) and (c). Evidence supporting compliance with provisions (a) and (b) include the invoices showing the use of interpreter services to provide language assistance to youth with limited English proficiency. Interviews with staff members provided evidence and of compliance with provisions (a) and (c), as they described the processes for providing PREA-related information to residents and reported that resident interpreters would not be used to assist youth in making a report of sexual abuse or harassment. The auditor made a final determination of compliance with provision (a) based on residents' understanding and ability to articulate the education they received. Resident interviews also supported evidence of compliance with provision (c) as they reported resident readers were not used to relay information or to assist in making reports. When considering whether staff members effectively communicated with residents, the auditor observed staff members interacting with youth during the audit and determined that general communication with youth was age and reading level appropriate. Since the facility demonstrated compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No

115.317 (b)

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? Yes No
- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? Yes No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? Yes No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? Yes No

115.317 (e)

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

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.317 (g)

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

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 340 – Criminal History Background Checks
3. Documentation demonstrating 5 year checks on randomly selected staff
4. Documentation demonstrating proper background checks on staff hired or promoted in the past 12 months
5. Documentation demonstrating proper background checks on a randomly selected contractor and volunteer

Interviews:

1. Facility human resources staff

Observations: No observations relative to this standard are required.

(a): IDJC policy prohibits hiring or promoting anyone who may have contact with residents and using the services of any contractor who may have contact with residents if the person:

1. "Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);

2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in (2) above.”

Ten personnel files selected by the auditor were reviewed. The files included random staff members, two staff members who were recently promoted, one volunteer, and one contractor. The selected files were reviewed to determine compliance with criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings. Three of the files selected were employees who had multiple criminal background checks as they had been employed at JCC – St. Anthony longer than 5 years.

(b): IDJC policy requires that for any person who may have contact with youth, the agency consider any incidents of sexual harassment in determining whether to hire, promote, or contract for services. During her interview, the human resources staff member said the application form contains questions about sexual harassment, and the annual evaluation contains questions about potential reportable PREA incidents.

(c): IDJC policy requires that before hiring a new employee who may have contact with residents, the agency, “through the cooperation of state and federal agencies, such as the Idaho Supreme Court, Idaho State Police, Idaho Department of Transportation, and the Idaho Department of Health and Welfare, has established a system to obtain a complete record search for background and criminal history information.” Checks conducted prior to employment include: criminal history checks, child abuse registries, self-declaration forms, and reference checks with prior institutional employers for information on substantiated allegations of sexual abuse or resignation pending an investigation of sexual abuse.

Criminal history records as defined in policy include “any or all of the following information relating to offenders: 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.”

The PAQ indicates that in the past 12 months, criminal background checks were conducted for 15 persons hired who may have contact with residents. During her interview, the human resources staff member verified the practice of conducting such checks for all employees and stated checks for volunteers and contractors are routed through a different department.

(d): IDJC policy requires that before enlisting the services of a contractor who may have contact with resident, the contractor(s) shall either submit to a background check and be cleared to perform services prior to use or have their services supervised by security staff. The PAQ indicates that in the past 12 months, criminal background checks were conducted for four persons contracted for services who may have contact with residents. During her interview, the human resources staff member said background checks are conducted for volunteers and contractors.

(e): IDJC policy requires a background checks to be conducted every five years. The human resources staff member stated background checks are conducted every five years, and employees are

fingerprinted again anytime they are promoted. Documentation reviewed on site indicated initial background checks for employees and contractors were conducted at five-year intervals.

(f): During her interview, the human resources staff member said the application form contains questions about sexual harassment, and the annual evaluation contains questions about potential reportable PREA incidents. These documents were reviewed on site, which confirmed the practice of requiring staff members to disclose information pursuant to this provision.

(g): IDJC policy states that “any material omissions or false information provided on the DJC-058 form are grounds for termination or disqualification.”

(h): Regarding future employment references, IDJC policy requires that “unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. “

Summary of Findings:

The auditor compared IDJC policy and the employment application process to the elements of this standard and the PREA Audit Tool, which require: a) the agency shall not hire or promote anyone who has engaged, been convicted of, or has been adjudicated to have engaged in sexual misconduct; and b) the agency consider incidents of sexual harassment when hiring or promoting employees or contracting services.

Based on the comparison, the auditor determined that IDJC policy aligns with the requirements of provisions (a) – (f). The auditor reviewed personnel files and determined necessary background and criminal history checks were conducted every five years as provision (e) requires. During interviews, the human resources staff member articulated the agency’s and facility’s hiring and promotion processes as described in policy and this standard. Two files of employees who had recently been promoted demonstrated that a background check was conducted prior to the promotion. The auditor determined IDJC and the facility demonstrated compliance with all provision, and thus, meets the requirements of this standard.

Corrective Action: None

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. Facility staffing plan including building schematics showing cameras and security mirrors
3. Email from Compliance Manager listing surveillance additions since the last PREA audit
4. Staffing plans for 2019, 2018, and 2017

Interviews:

1. Superintendent
2. Executive Director
3. PREA Compliance Manager

Observations:

1. Camera placement during facility inspection

(a): N/A, the facility has not acquired a new facility or made a substantial expansion to the existing facility since the last PREA audit.

(b): Since the facility's last PREA Audit, 7 additional video cameras and 1 additional server

were installed on the campus. The facility has also upgraded to higher quality cameras throughout the campus since the last audit. Several security mirrors were also added in cottages and the food service building to address identified blind spots.

The placement of the additional cameras and security mirrors were discussed with the Superintendent during the on-site audit. During his interview the Superintendent reported that the additional cameras were added as a result of on-going discussions that take place with the facility's leadership team. Reducing blind spots and increasing the safety of the youth and staff are routinely discussed in leadership meetings. The Compliance Manager includes identified blind spots in the facility's annual staffing plan. The Compliance Manager provided an email that included camera additions and security mirror additions made throughout the camera since the last audit. The additions were identified during the inspection of the campus.

Summary of Findings:

The auditor assessed the information provided for review along with interviews and observations made during the facility tour against the elements of this standard and the PREA Audit Tool which requires: b) when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

When considering compliance with provision (b), the auditor: 1) noted new camera placement during the facility inspection, and 2) reviewed the interview responses of the Superintendent and the Compliance Manger, and 3) reviewed the facility's staffing plans for the previous three years. The auditor was shown several additional cameras as well as additional security mirrors that had been added since the previous audit. The Superintendent stated during the interview that new cameras and additional mirrors were added to further protect the residents from possible sexual abuse. The staffing plans provided documentation that the facility was addressing previously identified areas of need and attempting to utilize the technology to enhance the safety of the youth.

For these reasons, the auditor determined compliance with provision (b), and thus the facility meets the requirement of this standard.

Corrective Action: None

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.321 (d)

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

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

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 835 – Sexual Assault
3. Freemont County MDT Protocol
4. Training records
5. MOU with the Family Crisis Center

Interviews:

1. Compliance Manager/Investigator
2. Random staff members
3. Compliance Coordinator
4. Advocate from the Family Crisis Center
5. SAFE/SANE nurse at Madison Memorial Hospital
6. Resident who reported a sexual abuse

Observations: No observations relative to this standard are required.

(a): The facility is responsible for conducting administrative investigations, and criminal investigations are referred to the Freemont County Sheriff's Office. When conducting a sexual abuse investigation, criminal investigators follow a uniform evidence protocol as evidenced by the Freemont County MDT Protocol, which addresses child abuse cases including sexual abuse, physical abuse, neglect, and cases involving unstable home environments. Facility staff members follow a uniform protocol as evidenced by the training document showing staff members who have completed the NIC Investigating Sexual Abuse in a Confinement Setting course. During her interview, the Compliance Manager/Investigator demonstrated an understanding of the evidence collection process. Random staff members articulated their first responder duties and stated they would separate residents, protect the scene, and notify supervisory staff members, and document the incident.

(b): The Freemont County MDT Protocol does not include details that the protocol is based on the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents." However, compliance with this provision was demonstrated, as the Freemont County Protocol states that the document was mandated by Idaho Code § 16-1617 and was developed in response to an increase in the number and severity of child abuse cases including sexual abuse, physical abuse, neglect, and cases involving unstable home environments.

(c): IDJC policy states that medical services pertaining to sexual assault, including forensic examinations, are provided free of charge. The policy indicates "IDJC Licensed Medical Staff are not permitted to collect medical information and evidence for forensic purposes from the alleged perpetrator

or alleged victim. The alleged victim is referred to a community facility and an IDJC staff member accompanies and supports the juvenile through the forensic medical examination process. Medical and mental health treatment by appropriate licensed health care professionals is provided while the juvenile is in IDJC custody.”

The PAQ indicates there have been no forensic examinations required or conducted in the previous 12 months. IDJC policy states that “the alleged victim is referred to a community facility and an IDJC staff member accompanies and supports the juvenile through the forensic medical examination process.” The facility’s coordinated response plan indicates one of the responsibilities of the Compliance Manager/Investigator is to contact the Family Crisis Center “in advance to inform them that an alleged rape victim is being transported to the forensic medical examiner so that they may be present on-site to provide services.”

The PAQ refers the auditor to the MOU with the Family Crisis Center, which indicates victim advocacy services would be provided if needed. The facility’s coordinated response plan indicates one of the responsibilities of the Compliance Manager/Investigator is to refer residents for a forensic examination by contacting the Madison Memorial Hospital. During her interview, the SAFE/SANE nurse said a SAFE/SANE nurse is always on call and always available to provide forensic examinations for St. Anthony residents. She said an advocate would be notified and would be present during the exam.

(d): The auditor reviewed the MOU between St. Anthony and the Family Crisis Center interviewed the an advocate employed by the crisis center, who stated that the MOU was in place and advocacy services would be provided to St. Anthony residents.

The Compliance Coordinator noted in the Issues Log, “All juveniles involved in a PREA allegation/incident are offered follow-up medical & mental health services. A licensed clinician provides the mental health services. JCC-St. Anthony has not had to access the services of a victim advocate at the crisis center, but as per the MOU the Family Crisis Center has someone on call 24 hours a day. If a staff from St. Anthony were needed to provide these services, a licensed clinician the juvenile was familiar & comfortable with would be utilized.”

The Compliance Manager stated St. Anthony maintains an MOU and a close relationship with the Family Crisis Center. None of the residents interviewed who had reported a sexual abuse had cases requiring forensic exams or required the services of a victim advocate.

(e): As noted in provision (c), an IDJC staff member would accompany and support an alleged victim of sexual abuse during the forensic examination at a community facility. The staff member who would accompany the resident is a licensed clinician with whom the resident is comfortable. As noted in standard 115.353, although residents demonstrated general knowledge of outside victim advocacy services, none could name the entity that would provide this service.

(f): As indicated above in provisions (a), the facility is responsible for conducting administrative investigations, and criminal investigations are referred to the Fremont County Sheriff’s Office. When conducting a sexual abuse investigation, criminal investigators follow a uniform evidence protocol as evidenced by the Fremont County MDT Protocol, which addresses child abuse cases including sexual abuse, physical abuse, neglect, and cases involving unstable home environments. Facility staff

members follow a uniform protocol as evidenced by the training document showing staff members who have completed the NIC Investigating Sexual Abuse in a Confinement Setting course.

(g): The auditor is not required to audit this provision.

(h): The auditor is not required to audit this provision.

Summary of Findings:

The auditor assessed agency policy against the elements of this standard and the PREA Audit Tool, which require: a) following a uniform evidence protocol for obtaining usable physical evidence; b) using a developmentally appropriate protocol based on A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents; c) offering forensic medical examinations at no cost to the resident; d) attempting to make outside victim services available; e) providing a qualified victim advocate to accompany residents through the examination process; f) requesting the investigating agency follow the requirements of this standard; and g) ensuring the staff member who serves in this role is screened and receives education regarding sexual assault and forensic examinations. The auditor determined IDJC policy contains the requirements of all provisions of this standard.

Staff members' overall knowledge regarding the collection of evidence and actions to be taken following an allegation of sexual abuse supported compliance with provisions (a) and (b). Additional evidence supporting compliance with these provisions includes the facility's use of the National Institute of Corrections: A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents for investigator training and certificates of completion of this training. The facility entered into an MOU with an outside victim advocate/crisis service, which demonstrated compliance with provision (d). The auditor determined compliance with provision (f), as the Freemont County MDT protocol appears appropriate. Since the facility demonstrated compliance with all audited provisions, the auditor determined St. Anthony meets the requirements of this standard.

Recommendation:

1. The facility's coordinated response states that youth would be offered outside advocacy services if residents requested them. Since most youth were unaware of these services, provide additional education to the youth to ensure they understand they can request an outside advocate to accompany them to a forensic examination.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? Yes No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. IDJC Policy 614 - Investigations - PREA

4. IDJC Policy 910 - Investigations - Administrative
5. Criminal investigative reports

Interviews:

1. Agency Head
2. Investigative staff member

Observations: No observations relative to this standard were required.

(a): The PAQ indicates 12 allegations of sexual abuse or harassment were received, 12 of which resulted in an administrative investigation, and two of which (incident reviews #14 and #30) were referred for criminal investigation.

IDJC policies outline the procedures governing investigations of sexual abuse and harassment. Policy 613 requires that all allegations of sexual abuse or misconduct within IDJC facilities will be investigated and responded to accordingly. Policy 614 requires that all allegations of sexual abuse and harassment received, including third party and anonymous reports, be investigated promptly, thoroughly, and objectively, to the extent possible. Policy 910 requires that upon request of the Director, and under direction of the Deputy Attorney General assigned to IDJC, administrative investigations shall be conducted. The IDJC website contains information regarding investigations, contains a link to the agency policy addressing investigations, and a link and information on how to report suspected abuse.

The Agency Head said that an investigation must be completed for all allegations of sexual abuse or harassment and described the process for conducting administrative and criminal investigations, which includes beginning with fact finding, determining if the gathered facts warrant a referral to law enforcement, and/or continuing with an administrative investigation to determine what transpired.

Six police reports were provided during the pre-audit phase to demonstrate compliance with this provision. The reports include details of the allegation, suspect and victim information, notification of Miranda rights, interviews conducted, statements collected, video review, referrals to a child advocacy center, findings, contact with the facility, referrals to the county prosecutor, and whether charges were filed.

(b): IDJC Policy 614 requires that allegations that are clearly criminal or those where an initial investigation reveals evidence supporting criminal prosecution, are referred to the appropriate law enforcement agency for criminal investigation. This information is included on the IDJC website as described above. The agency documents criminal referrals as evidenced by the criminal investigation reports provided during the pre-audit phase and on site.

During his interview, the investigative staff member said if it becomes clear during an investigation that the matter appears criminal, the case would be referred. Allegations appearing criminal in nature are referred to the Fremont County Sheriff Office.

(c): The auditor reviewed the IDJC website, which includes information about PREA-related allegations. The link to Policy 614 is available to the public and includes details of criminal referrals to the appropriate law enforcement agency for criminal investigation.

(d): The auditor is not required to audit this provision.

(e): The auditor is not required to audit this provision.

Summary of Findings:

The auditor reviewed IDJC policies and criminal investigative reports and compared these document to the elements of this standard and the PREA Audit Tool, which require that: a) the agency ensures that an investigation is completed for all allegations, b) the agency ensures allegations are appropriately referred for investigation and this information is public, and c) if a separate entity conducts criminal investigations, the publication describes those responsibilities.

Based on review of agency policy, the agency website, and the criminal investigations; and interviews with the facility investigator and the Agency Head, the auditor finds the agency in compliance with this provision.

Corrective Action: None

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

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

115.331 (b)

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

115.331 (c)

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 665 – Training Requirements
3. PowerPoint presentation: Prison Rape Elimination Act
4. Training Progress Report
5. PREA Information/Training Refresher Quizzes

Interviews:

1. Random staff members

Observations:

1. Interactions between staff members and youth

(a): IDJC policy stipulates within 45 days of being hired, all staff members will successfully complete many trainings including “PREA Basics for First Responders (one-hour initial classroom training and/or online annual refresher with bi-annual one-hour classroom training).” During interviews, random staff members reported they had been trained on each element during their initial and annual refresher training. The PowerPoint presentation: Prison Rape Elimination Act used for face-to-face staff training is comprehensive and addresses each item pursuant to this provision. The results of the online refresher training are included in the Training Progress Report and indicate the training status of staff members including passed, failed, in progress, or not started. The uploaded report showed the current status of “passed” for all staff members.

(b): The training materials are tailored to the unique needs of residents and although the training materials are not gender-specific, they are appropriate for males and females and include information regarding LGBTI and gender-nonconforming residents. Additionally, the Compliance Manager noted in the PAQ that training specific to female juveniles is provided through “Voices Training.” The Compliance Manager also noted that when a staff member transfers to a different cottage, training occurs through a mentorship of current cottage staff members to the newly transferred cottage staff member.

(c): The facility reported that 170 employees are currently employed by the facility who may have contact with youth, all of whom were trained or retrained on the PREA requirements outlined in provision (a). Staff members receive the face-to-face comprehensive training included in the PowerPoint presentation every other year and refresher online trainings during the year they do not receive the in-person training.

(d): IDJC documents the training staff members receive as evidenced by the uploaded Training Progress Report and PREA Information/Training Refresher Quizzes.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) employees receive training on 11 specific topics; b) the training is unique to the characteristics of the facility and additional training is provided when a staff member transfers from a male to female living unit, or vice versa; c) training remains current and refresher training occurs every two years; and d) training is documented in the Traincaster system.

The auditor determined the training materials address each of the 11 elements pursuant to provision (a), which supports compliance with provisions (a) – (c). The auditor interviewed random staff members and concluded they received, understood, and communicated sufficient knowledge about the 11 items during annual and refresher training. The auditor observed female staff members following PREA guidelines when entering cottages, as they announced their presence when entering. The auditor also observed staff members communicating professionally with youth. The auditor reviewed the training materials and determined the topics are applicable to the characteristics of St. Anthony youth, as the training is juvenile-specific, which supports compliance with provision (b). The auditor reviewed annual and refresher training records in the Traincaster system to determine compliance with provision (c). Since the facility demonstrated compliance with each provision, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. Training records

Interviews:

1. Volunteer who have contact with residents
2. Contractor who has contact with resident

Observations: No observations relative to this Standard were required.

(a): The PAQ indicates all volunteers and contractors have received training about the facility's zero tolerance policy, and that 59 individuals have received the training in the past 12 months. During interviews, the one volunteer (foster grandmother) and one contractor (occupational therapist) reported receiving training on their responsibilities regarding sexual abuse prevention, detection, and response before having contact with the residents. They said they were trained on the facility's zero tolerance policy, how to make a report, what should be reported, and to whom to report. They said the training was provided when they first gained access to the campus and on several occasions thereafter.

(b): The facility reported that the level and type of training the volunteers and contractors receive is based on the services they provide and level of contact with youth. The Training Course Completion Survey forms and corresponding quizzes and the PREA Information Training Refresher and corresponding quizzes were provided for the two individuals interviews as well as for other contractors and volunteers.

(c): The Training Course Completion Survey and PREA Information Training Refresher forms indicate volunteers and contractors receive initial and refresher PREA-related training.

Summary of Findings:

The auditor assessed training records against the elements of this standard and the PREA Audit Tool, which require that: a) volunteers and contractors who have contact with residents receive training, b) the level of training is based on the service provided and level of contact, and c) the training is documented. The auditor determined the training provided supports compliance with provisions (a) – (c). The auditor interviewed one volunteer and one contractor to confirm they received and understood the PREA-related training, which support compliance with provision (b). The auditor reviewed the quizzes and surveys, which contained signatures confirming training was received and understood, which supports compliance with provision (c). Based on the interview responses and documentation review, the auditor determined sufficient evidence was present for each provision, and thus St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.333: Resident education

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

115.333 (a)

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

115.333 (b)

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

115.333 (c)

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

115.333 (d)

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

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? Yes No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 640 – Observation and Intake
3. PowerPoint presentation: PREA Basics for Juveniles
4. Juvenile Understanding of Prison Rape Elimination Act form
5. Electronic records with dates of assessments and PREA education
6. Juvenile/Parent Handbook
7. Intake records including youth education

Interviews:

1. Intake staff
2. Random youth
3. Compliance Coordinator

Observations:

1. Posters containing PREA-related information

(a): IDJC policy requires that residents receive “necessary information and documents, including explanation and clarification by staff as needed, and is asked to sign related forms.” One of the forms is the Juvenile Understanding of Prison Rape Elimination Act (PREA) (DJC-162), which is placed in the resident’s case management file. The PAQ indicates 82 residents entered the facility and received PREA-related information during their intake, and the intake staff member said residents receive PREA education the day the resident arrives or on the second day at the latest. During their interviews, all residents reporting receiving PREA education on the day of their arrival, which included reading through a packet, discussing it with a staff member, and watching the PREA video. The Juvenile Understanding of Prison Rape Elimination Act forms in English and Spanish were provided prior to the on-site audit, and during the on-site audit, resident files and electronic records were reviewed and contained completed forms with signatures and dates indicating resident’s receipt of PREA education. Electronic records included a spreadsheet containing resident program arrival date and the date he or she was provided PREA education within 10 days.

The auditor noted zero tolerance posters in Spanish and English displayed throughout the campus during the facility inspection. The PowerPoint presentation for residents contains comprehensive information about the PREA, the facility’s zero tolerance policy, residents’ right to be free from sexual abuse or harassment, right to be free from retaliation for reporting, definitions, reporting options, investigations, and a quiz. The Juvenile/Parent Handbook includes the following:

- A description of the PREA
- Zero-tolerance policy
- Key concepts about sexual assault, sexual misconduct, and investigations
- Reporting methods including grievance forms, telling a trusted staff member, third party reporting, and calling a parent, guardian, outside agency, or probation officer.

The intake staff member said PREA-related information is also available in the intake packet and the intake staff member reviews all information with residents. He also said the resident is allowed to read through the packet and takes an exam. Any incorrect answers are discussed with the resident to ensure understanding. During their interviews, all residents reporting receiving PREA education on the day of their arrival, which included reading through a packet, discussing it with a staff member, and watching the PREA video.

(b): IDJC policy requires that within 10 calendar days of admission to the facility, youth receive education regarding PREA. The auditor determined the education they receive within this timeframe was comprehensive. During his interview, the intake staff members state that on the first day of arrival, or second day at the latest, youth receive this information. During youth interviews, they verified this practice and said they received the education and watched the PREA video during intake and multiple times throughout their stay. Every time a new group member is received, the whole group watches the PREA video.

(c): Agency policy does not require that IDJC provide the PREA education each time a youth transfers to a different IDJC-operated facility. However, in a follow-up email, the Compliance Coordinator indicated the three IDJC facilities are all state-operated and bound by the same PREA compliance policies, use the same PREA education and training materials, and have similar investigation, reporting, and prevention processes. For these reasons, youth who move from one state-operated facility to another are not required to participate in additional PREA education, as they would have already received the education at the previous facility.

d): As noted in 115.316, resources are available for providing youth education in formats that are accessible to limited-English proficient and disabled residents or those that have limited reading skills. In the Issues Log, the Compliance Manager noted, “Depending on the disability IDJC would make accommodations accordingly. JCC-St. Anthony has several juveniles who are cognitively delayed & when the training is taught to them those Group Leaders make sure that they are going at a pace that the juvenile understands. Any juveniles that are a behavioral health referral are identified at the front end & the Group Leader knows what accommodations need to be made.”

(e): The facility documents resident participation in PREA education by requiring residents to acknowledge their understanding by signing and dating the Juvenile Understanding of Prison Rape Elimination Act form. As noted in provision (a), a spreadsheet containing resident program arrival date and the date he or she was provided PREA education was uploaded and indicated all residents received the education within 10 days.

(f): PREA information is available and visible to youth through posters and educational material on the cottages. The auditor noted the posters were visible in dorms and common areas during the facility inspection. Youth said they received PREA-related information during intake and continuously throughout their stay as the PREA educational video is played for the cottage each time a new youth joins the group.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) during intake, residents receive PREA-related information in an age-appropriate manner; b) within 10 days, residents receive comprehensive age-appropriate PREA education; c) current residents who have not received PREA-education, shall be educated within one year; d) education is provided in accessible formats; e) resident education is documented; and f) key information is available and visible.

The auditor determined IDJC policy addresses provision (a) but does not explicitly address provisions (b) and (c). A review of electronic intake records, resident signature sheets, and the resident handbook demonstrated that the facility is compliant with provision (a) because the information is comprehensive and the materials are written in a way that residents with disabilities are able to understand the information. Residents with these designations reported receiving and understanding the PREA education, which provided the auditor with sufficient evidence of compliance with provisions (a) – (f). The auditor determined compliance with provision (b) based on interviews with the intake staff member and residents who stated the facility provides comprehensive education within 10 days of intake and the spreadsheet containing residents’ arrival date and date they received the PREA education. Staff and youth interviews verified that residents receive the required PREA education not only within the 10 day period but frequently throughout their stay as the PREA video is played every time a new youth arrives on a cottage. The auditor determined compliance with provision (c), as the facility reported that

all youth had received the education, and residents said they received the education. The same method for Standard 115.316 and provision (a) of this standard was used to determine compliance with provision (d); the auditor concluded that the handbook provided sufficient evidence that written PREA information is in a format that is accessible to youth with disabilities and/or low reading skills. The resident signature sheets provided evidence for the auditor to determine compliance with provision (e). During the facility inspection, the auditor noted the placement of posters containing PREA-related information that were visible in resident cottages and other common areas which demonstrated compliance with provision (f) of the standard. Since the facility demonstrated compliance with all provisions, the auditor determined that St. Anthony meets the requirements of this standard. Youth and staff interviews confirmed that not only are the educational requirements required by the standard met, but they are exceeded by the fact that the youth are continuously provided PREA education during their stay as the entire group receives orientation, including watching the PREA video, each time a new youth is received on a cottage.

Corrective Action: None

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
 Yes No NA

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 665 – Training Requirements
3. Training Progress Report for Investigators
4. National Institute of Corrections (NIC) Training Course

Interviews:

1. Investigator

Observations: No observations relative to this standard were required.

(a): In addition to the first-responder PREA training all staff members receive, IDJC policy requires that facility staff members who investigate allegations of sexual abuse receive additional training in “Sexual Abuse in a Confinement Setting (National Institute of Corrections – online) as determined by Division Administrators.” The training link was to the National Institute of Corrections training course titled PREA: Investigating Sexual Abuse in a Confinement Setting. The investigator interviewed stated he received this training and described a large number of PREA-related annual and on-site trainings he had attended.

(b): As noted above, IDJC policy requires investigators to participate in the National Institute of Corrections course and provided the link to the online course. The investigator said he received the training, which including Miranda and Garrity warnings, techniques for interviewing juveniles, evidence collection, and the criteria to substantiate a case. He said if it becomes clear the case is criminal in nature, the case is referred to law enforcement.

(C): The results of the online training are included in the Training Progress Report and indicate the status of the 24 facility investigators as passed, failed, in progress, or not started. The uploaded report showed the current status of “passed” for all investigators.

(d): This subsection does not apply; the agency is responsible for conducting administrative investigations. The Fremont County Sherriff Department conducts criminal investigations.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) facility investigators receive additional training in conducting investigations, b) the training contains specific elements, and c) the completion of the training is documented.

The auditor concluded each element of this standard is sufficiently referenced in policy, which supports compliance with provisions (a) – (c). The progress report showed that all investigators passed the online training course, which provides additional evidence of compliance with provisions (a) – (c). Further compliance was demonstrated during the interview with the facility investigator, as he provided details about and communicated understanding of the training he received. Compliance with provision (c) was determined based on the training report provided to the auditor. Since the facility demonstrated compliance with all provisions, the auditor concluded St. Anthony meets the requirements of the standard.

Corrective Action: None

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and

professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 665 – Training Requirements
3. Training Progress Report for Medical and Mental Health Care Providers

Interviews:

1. Medical and mental health care staff

Observations: No observations relative to this standard were required.

(a): In addition to the first-responder PREA training all staff members receive, IDJC policy requires that facility medical and mental health care staff members complete a “specialized class for Mental Health and Medical First Response for PREA (online and annual online refresher).” The PAQ indicates that 100% of the 19 staff members in this category received the required training.

(b): This subsection is not applicable; the facility medical staff members do not conduct forensic examinations. IDJC policy and coordinated response plan require that an off-site SANE/SAFE nurse conduct exams of this type.

(c): The results of the online training are included in the Training Progress Report and indicate the status of the 19 medical and mental health care providers as passed, failed, in progress, or not started. The uploaded report showed the current status of “passed” for all staff members in this category.

(d): IDJC policy requires that medical and mental health staff are trained in each of the 11 required elements outlined in Standard 115.331 (a) and are required to complete additional training specific to medical and mental health care providers who may be first responders. The PowerPoint presentation addresses each item and provides a comprehensive PREA education. During interviews, medical and mental health care staff reported they had been trained on each element during their annual and refresher trainings.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) medical and mental health care staff members receive PREA-related training, b) medical staff who conduct forensic examinations receive PREA-related training, c) the training is documented, d) medical and mental health care staff members receive training pursuant to standard 115.331 and/or 115.332. The auditor determined each element of this standard is addressed in policy, which supports compliance with provisions (a) – (d). The training progress report of medical and mental health care staff members as well as the responses given during interviews led the auditor to a determination of compliance with provision (a). Provision (b) was not applicable, as the auditor confirmed forensic examinations are conducted off site. The auditor determined compliance with provision (c) because the training progress report showed that all medical and mental health care

providers have passed the required training. Since the auditor concluded the facility is compliant with each provision, St. Anthony meets the requirements of this standard.

Corrective Action: None

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

115.341 (b)

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

115.341 (c)

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

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? Yes No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? Yes No
- Is this information ascertained during classification assessments? Yes No
- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? Yes No

115.341 (e)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 404 – Observation and Assessment Evaluations
3. IDJC Policy 640 – Observation and Intake
4. IDJC Policy 613 – PREA Compliance
5. Risk of Sexual Victimization/Perpetration Screener (RSVP)
6. Completed RSVP forms

Interviews:

1. Random residents
2. Staff responsible for risk screening
3. Compliance Manager
4. Compliance Coordinator

Observations: No observations relative to this standard were required.

(a): IDJC Policy 640 requires that “juveniles are promptly screened to identify risk to self or others, to assess for immediate medical and mental health needs, and are given basic information, including a description of their rights and responsibilities while in IDJC custody.”

IDJC Policy 404 requires that, “Every juvenile admitted to O&A is administered a Risk of Sexual Victimization/Perpetration Screener (DJC-269) by a Clinician within three calendar days of the juvenile’s entry into O&A.”

IDJC Policy 613 requires that, “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 six months after the date of placement.”

The facility reported on the PAQ that 80 youth entered the facility in the past 12 months and that all were screened for risk of sexual victimization or perpetration. Five resident files were reviewed during the on-site portion of the audit and indicated the RSVP screening tool was used on the date the resident entered the facility.

During interviews, the staff member responsible for risk screenings reported screening residents upon admission or transfer from another facility for risk of sexual abuse victimization or abusiveness with 72 hours of the resident’s arrival. The staff member said this information is ascertained during a file review and the interview with the resident. He said the screening is used during intake and every six months thereafter.

During interviews with random youth, all reported being asked the questions in the RSVP on their first day. While several of the youth said this was the only time they were asked these questions again, most said they were asked the questions again several months to six months later.

(b): The auditor reviewed the RSVP form and determined the assessment was an objective screening instrument.

(c): The RSVP form is used to obtain the 11 items per this standard. The staff member responsible for the screening could articulate details of the items the risk screening considers.

(d): The staff member who conducts the screening said he asks the residents questions from the screening during an interview.

(e): The intake staff member said information from the RSVP is restricted to clinicians and supervisors. The Compliance Manager reiterated that the information gained during the screening is restricted to clinicians, supervisors, and the Compliance Manager. The Compliance Coordinator said the screenings are completed and pertinent staff members are informed of the risk level. He said the information is stored in a secure data management system, which is only accessible by clinical-level staff members.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) the resident's history is reviewed within 72 hours and periodically, b) the assessment is objective, c) the agency ascertains information about each of the items per this provision, d) the information is ascertained through conversation and records review, and e) the dissemination of information is controlled. The auditor determined that each element of this standard is addressed, which supports compliance with provisions (a) – (e).

Although not all youth reported being asked these questions throughout their stay at St. Anthony, the auditor reviewed risk assessments and concluded the assessments were conducted during intake and throughout the resident's confinement, which supports compliance with provision (a). The assessment procedures appear to be conducted in a similar manner for each resident, which supports compliance with provision (b). The auditor compared the assessment to the items in provision (c) and determined that each item is addressed, which supports compliance with this provision. During interviews, the staff member who conducts the screening and residents reported that the intake process includes gleaning information through an interview. The staff member said information gained during the interview and file review is reviewed and considered, which supports compliance with provision (d). Compliance with provision (e) was determined based on the auditor's observation of the resident file storage and interview responses, which indicate access to the screening information is limited. Since the facility demonstrated compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.342: Use of screening information

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

115.342 (a)

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

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA

115.342 (c)

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

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? Yes No

115.342 (d)

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

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

115.342 (i)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. IDJC Policy 404 – Observation and Assessment Evaluations
2. IDJC Policy 604 – Special Management Interventions
3. IDJC Policy 613 – PREA Compliance
4. IDJC Policy 640 – Observation and Intake
5. IDJC Policy 672 – Nondiscrimination of Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning Juveniles
6. Several JCC-SA Program Referral Packets

Interviews:

1. Compliance Manager
2. Staff responsible for risk screening

Observations: No observations relative to this standard were required.

(a): IDJC Policy 640 stipulates that once information is obtained from multiple intake assessments, including the risk screening, “the Clinical Supervisor or designee will refer the juvenile to the appropriate program placement.”

IDJC Policy 404 stipulate that “within the first 20 business days of O&A placement, the Clinical Supervisor, or designee, facilitates the O&A staffing and includes the JPO, juvenile, Clinician who completed the O&A evaluation, parent/guardian, JSC, and other necessary participants (e.g., licensed

medical staff, education staff, Rehabilitation Technician staff). If the JSC is unable to attend a staffing, it is the JSC's responsibility to follow up with the Clinical Supervisor regarding the staffing recommendations." Policy also requires that "consideration is given to the specific needs, behaviors, and vulnerabilities as indicated by screeners and assessments completed during the O&A process" when placement options are considered.

The Compliance Manager and staff member responsible for screening for risk said screening information is considered when determining if the youth is appropriate for St. Anthony and any indicators of risk are flagged and forwarded to clinical staff members.

(b): IDJC Policy 604 requires that isolation is only used as "an adjunct to the treatment process when a juvenile's behavior seriously endangers the safety and security of others or the facility." Policy states that documentation indicating all other less restrictive means have been exhausted must accompany all incidents of isolating residents. The facility reported that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

If a resident is isolated, policy states the resident must be provided 1) due process hearings at least every 24 hours to ensure the resident's constitutional rights are not violated, 2) daily access to recreation and exercise, 3) legal counsel, 4) education, and 5) a manifest determination meeting for residents who receive special education services. During interviews, the Superintendent and medical/mental health care staff said isolation is not used. No residents who had been segregated were interviewed, because none were present during the audit.

(c): IDJC Policy 672 requires that "LGBTIQ juveniles are not placed in a particular housing unit, bed or other placement based solely on the juvenile's LGBTIQ status, or perceived status." Policy also states the "IDJC shall not consider a juvenile's LGBTIQ status, or perceived status, as an indicator or likelihood of being sexually abusive." The Compliance Coordinator and Compliance Manager said St. Anthony does not have special housing units. The two transgender residents said they are not housed separately or in specific cottages and reported showering alone.

(d): IDJC Policy 672 requires that "staff 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." The Compliance Manager said whether or not a resident is LGBTI is not a factor when determining housing assignments. The two transgender residents confirmed they were not housed separately.

(e): IDJC Policy 613 states that 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 six months after the date of placement."

Additionally, IDJC Policy 404 requires the facility or regional Clinical Supervisor to request updated assessments to determine current treatment and placement needs if at any point it is determined that a juvenile is not making progress or will not complete program. The Compliance Manager and staff responsible for risk screening said that residents' safety and security was considered when making room and bed assignments.

(f): As noted in provision (d), IDJC Policy 672 requires that residents' preference of being housed with females or males is considered when making placement decisions. The Compliance Coordinator and Compliance Manager corroborated this practice during interviews.

(g): IDJC Policy 672 requires that transgender residents use a separate shower and bathroom, and when separate showers are not available, these residents shower first or last. Interviews with staff members and transgender residents confirmed that all residents shower separately.

(h): The facility reported that no residents at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified isolation is not used at St. Anthony.

(i): IDJC Policy 604 requires due process hearings at least every 24 hours, which exceeds the 30-day review requirement. No staff member responsible for monitoring youth in isolation was interviewed, as the facility does not have rooms or areas used for this purpose.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) the agency uses information gained pursuant to Standard 115.341 to make placement decisions designed to keep all residents safe; b) residents are isolated as a last resort and if they are isolated, resident receive access to exercise and education; c) LGBTI residents are not placed in specific housing based on this status; d) placement decisions are made on a case-by-case basis; e) placement decisions for transgender and intersex youth are reassessed twice per year; f) the views of transgender and intersex residents are given serious consideration; g) transgender and intersex are given the opportunity to shower separately; h) isolation of residents is documented; and i) residents held in isolation receive a review every 30 days.

The auditor determined that all provisions are sufficiently addressed in IDJC policy, which supports compliance with provisions (a) – (i). The Compliance Manager stated that this information is used to placements, which evidenced the implementation of provision (a). Staff members' and residents' responses during interviews confirmed that isolation is not used, which supports compliance with provisions (b), (h), and (i). Staff responses during interviews supported compliance with provision (c). Since sufficient evidence was present to determine compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

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

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.351 (d)

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

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 675 – Privileged Communications
3. IDJC Policy 671 – Juvenile Grievance
4. PowerPoint presentation: PREA Basics for Juveniles
5. Juvenile/Parent Handbook
6. Juvenile Grievance Filing form
7. Resident grievances alleging sexual abuse or harassment
8. Notification of Disclosure and/or PREA Incident
9. Investigative reports containing evidence that verbal reports are documented and reported

Interviews:

1. Random staff members
2. Youth who reported a sexual abuse
3. Random residents
4. Compliance Manager

Observations:

1. Posted hotline numbers

(a): The PowerPoint presentation indicates residents have multiple ways to report abuse or harassment to a trusted staff member, parent, JSO, or JPO, or by submitting a grievance or calling or writing the outside source that is posted on PREA posters located throughout the facility. The presentation also informs residents they may make anonymous reports using any of these reporting options. The posters containing the phone number and address to an outside source were observed during the facility

inspection and were located in areas accessible to staff members and residents. Similar information is included in the Juvenile/Parent Handbook. During their interviews, residents were able to articulate the various ways to make a report. Most said they would submit a grievance or report to a staff member. During interviews with random staff members, they described the various ways residents may report including reporting anonymously.

(b): The Juvenile/Parent Handbook indicates residents may report to a third party but does not include the number or address of the third party. IDJC policy pertaining to privileged communication stipulates that residents wishing to report to outside entity may do so, and the communication is considered privileged. The policy states that if the juvenile wishes to report during a phone call, staff members provide the juvenile privacy during the call; if the juvenile wishes to mail the report, he or she may seal the mail addressed to the Child Abuse/Neglect Reporting Agency and are not required to include a return address. The policy includes the address and phone number of the outside agency. During their interviews, all residents said they could submit a report privately, but several were unsure if they could do so anonymously. The Compliance Manager said victim advocacy numbers are posted in every unit on campus and that staff members are instructed to assist the resident in connecting the call and step away to give the resident privacy during the call. The posters were observed during the facility inspection. The agency does not house residents detained solely for civil immigration purposes; therefore, the second portion of this provision is not applicable.

(c): IDJC policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must be promptly reported. Residents articulated an understanding of several reporting options available to them, but several were not sure if they could make a report anonymously; however, the PowerPoint presentation includes information about residents' right to report anonymously. Staff members articulated this right during their interviews.

(d): The PowerPoint presentation, handbook, and policy indicate written grievances alleging sexual abuse or harassment are accepted. Grievance forms may be placed in envelopes, which are placed in locked boxes in resident dorms. Additionally, there is a box on the top of the grievance form and front of the envelope marked Sexual Abuse/Sexual Harassment that residents may check before they place the envelope in the locked box. The locked boxes are checked daily by Safety and Security Officers and any envelopes marked Sexual Abuse/Sexual Harassment result in immediate contact being made with the Compliance Manager who follows up with the youth. During interviews with random residents, they said they had access to grievance forms and could drop the completed grievance into a locked box. Three written grievances alleging PREA-related incidents and the corresponding Notification of Disclosure and/or PREA Incident were uploaded. The forms indicate on the same day a resident reports a PREA-related concern, the Superintendent, Clinical Supervisor, Duty Officer, Program/Unit Manager, Rehabilitation Specialist, Juvenile Service Coordinator, and Juvenile Probation Officer are notified of the report.

(e): IDJC provides staff members the same reporting options as residents, and during interviews, the staff were able to articulate an understanding of the ability to report anonymously and privately.

Summary of Findings:

The auditor compared IDJC policies and the documents listed above the elements of this standard and the PREA Audit Tool, which require that: a) the agency provides multiple ways to privately report sexual abuse or harassment; b) residents are provided an anonymous reporting option to an outside entity, and residents detained for civil immigration shall be provided information on how to contact consular officials; c) staff shall accept verbal, written, anonymous, and third party reports and must document

verbal reports; d) residents have the tools needed to make written reports; and e) staff have a method to privately report sexual abuse or harassment of residents.

The auditor determined that each element of this standard is included is addressed in policy, which supports compliance with provisions (a) – (e). To support compliance with provisions (a) and (b), the auditor noted the hotline numbers posted throughout the facility and included in policy. The majority of residents said they could report anonymously and resident education materials indicate they are instructed that they may do so, which supports compliance with provision (b). A determination of compliance with provisions (c), (d), and (e) was based on interview responses about the procedures for making reports, grievances alleging sexual abuse or harassment, and the prompt notifications to appropriate staff members. The facility demonstrated compliance with each provision; thus, the auditor determined ST. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) Yes No NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) Yes No NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) Yes No NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 671 - Juvenile Grievance
3. Juvenile/Parent Handbook

Interviews:

1. Residents who reported a sexual abuse

Observations: No observations relative to this standard were required.

(a): IDJC Policy 671 states that IDJC provides an administrative means for handling complaints from juveniles related to their care and confinement as well as a means for juveniles to report PREA-related incidents; therefore, the facility is not exempt from this standard. Policy allows a juvenile to submit a grievance without having to ask for the form, as grievance forms and envelopes are made readily available.

(b): IDJC policy 671 states that there is no time limit on when a juvenile may submit a grievance for allegations of sexual abuse. The PAQ indicates the facility does not require residents to use an informal grievance process to allege an incident of sexual abuse. Neither IDJC policy nor the Juvenile/Parent Handbook includes a description of any informal process, which further supports compliance with this provision.

The handbook includes the following:

- A description of the PREA
- Zero-tolerance policy
- Key concepts about sexual assault, sexual misconduct, and investigations
- Reporting methods including grievance forms, telling a trusted staff member, third party reporting, and calling a parent, guardian, outside agency, or probation officer

(c): The PAQ indicates residents are allowed to submit grievances without submitting them to the staff member who is the subject of the complaint. IDJC Policy 671 states that if the grievance involves a staff member, the grievance will be assigned to a different staff member. Policy also states that a juvenile may complete the form, place it in a sealed envelope, and place the envelope in a locked grievance box, and only the safety and security officer or designee has a key to the boxes. Additionally, a third party may submit a grievance on behalf of a resident by submitting a grievance form or using the public website.

(d): IDJC Policy 671 states that all grievances marked as sexual abuse or harassment are handled as an emergency grievance and are immediately delivered to the facility PREA Compliance Manager. Policy also states that a review of any type of grievance must be conducted within three working days of receipt of the form. If the form is marked as sexual abuse or harassment, an initial response and corrective action must be provided within 48 hours, and the Superintendent's final decision must be

reached according to all other grievances, which is three working days. If a full investigation of the grievance is warranted, an extension of 30 days must be requested, and the juvenile must be notified of the need of the extension within five days of receipt of the grievance. This process exceeds the requirements of this provision, which state that a decision must be made within 90 days.

All but one initial incident reviews were dated on the same day the report was received. None exceeded 48 hours, and all final review decisions were made within 30 days. All written grievance alleging sexual abuse or harassment were received within one to two days after the date the resident wrote the grievance.

The facility reported receiving four grievances alleging sexual abuse or harassment and indicated all were resolved within 90 days. No extension past 90 days was needed; therefore, no resident was notified an extension was requested. The facility uploaded three corresponding incident review forms, which included the review team's determinations and corrective actions taken. The facility also provided a sample of three Notifications of Disclosure and/or PREA Incident forms (incidents #14, #30, and #40). All three contained documentation of verbal PREA-related reports made by residents, and each had a corresponding incident review with the review team's determinations and corrective actions taken. Two of these reports (#14 and #30) were investigated by law enforcement, as evidenced by the corresponding sheriff report. The county prosecutor declined filing charges for both cases.

During their interviews, four residents who reported a sexual abuse stated they were informed of the results of the investigation in a written report and/or verbally within 90 days. The length of time between the dates they made the report to the dates they received an outcome decision ranged from two weeks to approximately three months.

(e): IDJC policy states that grievances may be filed by a third party on behalf of the resident. These grievances will not be addressed unless the juvenile agrees to have the grievance filed on their behalf. If the grievance is filed a parent or legal guardian on a juvenile's behalf, the grievance will be addressed regardless of whether the juvenile agrees to have the complaint filed on their behalf. Additionally, the Juvenile/Parent Handbook lists third-party reports as an accepted reporting method.

The PAQ indicates no third-party reports were received during the previous 12 months.

(f): IDJC Policy 671 states that all grievances marked as sexual abuse or harassment are handled as an emergency grievance and are immediately delivered to the facility PREA Compliance Manager. The policy also states an initial response must be provided and corrective actions taken within 48 hours as required by this provision. A final decision by a supervisor or designee must be reached within three working days, which exceeds the timeline of five working as required by this provision.

The PAQ indicates no grievances alleging substantial risk of imminent sexual abuse were filed in the previous 12 months. None of the grievances reviewed by the auditor described imminent risk of sexual abuse.

(g): IDJC Policy 671 states that if it is found that a juvenile intentionally filed an emergency grievance where no emergency exists, an appropriate program response may be initiated. The facility reported there have been no resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed a grievance.

Summary of Findings:

The auditor reviewed IDJC policy and the juvenile/parent handbook and compared these documents to the elements of this standard and the PREA Audit Tool, which require that: a) the agency has administrative procedures for dealing with sexual abuse allegations; b) the agency does not impose a time limit to submit a grievance regarding sexual abuse, may apply time limits on a portion of the grievance that does not allege sexual abuse, shall not require the use of an informal grievance process, the agency's ability to defend against a lawsuit based on the statute of limitations; c) residents may submit a grievance without submitting it to the staff member who is the subject of the complaint; d) the agency shall issue decisions about a allegations of sexual abuse within 90 days; a 70-day extension may be issued; if the resident does not receive a decision within the administrative process time limit, the resident may consider the absence of a response to be a denial at that level; e) third parties may assist residents in filing administrative remedies relating to sexual abuse; if third parties other than parents of guardians files such a request, the facility may require the alleged victim to agree to have the request filed on his/her behalf; if the resident does not agree, the facility must document the resident's decision; a parent may submit this request without the youth's agreeing to have the request filed on his/her behalf; f) the agency shall establish procedures for the filing of emergency grievances of imminent sexual abuse and immediate action must be taken to protect the resident; and (g) residents may be disciplined for alleging sexual abuse in bad faith.

St. Anthony is not exempt from provision (a) because the facility has administrative procedures to address resident grievances regarding sexual abuse. After a review of policy, Juvenile/Parent Handbook, dated grievances, incident review forms, police reports, and interviews with the Compliance Manager, Superintendent, random staff, and residents who reported a sexual abuse, the auditor determined the facility meets the requirements of each provision. Additionally, the auditor determined the facility exceeds the timelines required in provision (d) and (f) finds; thus the auditor determined St. Anthony exceeds the requirements of this standard.

Corrective Action: None

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? Yes No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) Yes No NA
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.353 (b)

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

115.353 (c)

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

115.353 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 675 – Privileged Communications
3. IDJC 613 – PREA Compliance
4. PowerPoint presentation: PREA Basics for Juveniles
5. PowerPoint presentation: F2F Staff PREA Training
6. Memorandum of Understanding (MOU) with Family Crisis Center

Interviews:

1. Facility Superintendent
2. Executive Director of the Family Crisis Center
3. Random youth
4. Youth who reported a sexual abuse

Observations:

1. Phones in each cottage

(a): IDJC policy stipulates that IDJC will provide will provide for the medical and mental health needs of identified victims but does not include information about outside victim advocacy services. The PowerPoint presentations for staff members and residents include information about outside entity reporting but do not include information regarding outside victim advocacy services. However, IDJC policy pertaining to privileged communication stipulates residents wishing to receive outside support services may do so, and the communication is considered privileged. The policy states that if the juvenile may privately call or write to the victim advocacy service and that he or she may seal the mail. Additionally, the facility provided an MOU with Family Crisis Center, an outside victim advocacy service, stating the center will provide confidential emotional support services to resident victims placed in IDJC facilities.

During random youth interviews, all residents stated they knew outside services were available, but none could name the agency that would provide such services. During interviews with youth who reported a sexual abuse, they stated they were offered mental health services by St. Anthony, but were not informed of outside services. During a follow-up phone call, this information was shared with the PREA Coordinator who said additional education about outside advocacy services would be provided to any youth victim of sexual abuse or harassment.

(b): IDJC policy pertaining to privileged communication stipulates youth wishing to receive outside support services may do so, and the communication is considered privileged. The IDJC Juvenile Notice of Limited Confidentiality form includes information about the limits of confidentiality and lists the disclosures that must be reported. During interviews with random youth and residents who reported sexual abuse, they stated they understood the general limits of confidentiality but did not demonstrate an understanding of the limits specific to an outside victim advocate, as they were unaware they had access to these services.

(c): An MOU with a crisis center indicated an agreement was established to provide services. The auditor interviewed an advocate employed by the crisis center who confirmed the MOU with St. Anthony was in place. She said the center provided training and resident education at the facility and had done so recently. She stated the center had not provided advocacy services to St. Anthony youth but would provide these services if needed.

(d): IDJC policy states that residents shall have access to legal counsel and if the resident needs assistance obtaining legal services or needs assistance in reaching counsel already in place, IDJC staff members will assist them. During their interviews, the Superintendent and Compliance Manager said residents may call their attorney twice per week and may visit privately with their attorneys during visitation. They said facility staff members assist residents in making this contact as needed. Random residents and residents who reported a sexual abuse reported having access to their attorneys.

Summary of Findings:

The auditor compared agency policy with the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall provide residents access to outside victim advocates related to sexual abuse, b) the facility inform residents of the extent to which communications are monitored and of mandatory reporting, c) the facility shall attempt to enter into an MOU with community service providers that provide residents with emotional support services, and d) the facility shall provide confidential access to legal representation. Policy addresses all provisions supporting compliance with provisions (a) – (d). Residents general knowledge of outside victim advocacy services and limits of confidentiality supported compliance with provisions (a) and (b). The MOU with an outside victim advocacy center supported compliance with provision (c). Since provided the auditor with sufficient evidence of compliance with provisions (a) - residents based on youths' lack of knowledge of these services, and thus lack of knowledge of the limits of confidentiality, the auditor determined the facility did not demonstrate compliance with provisions (a) and (b). The auditor relied upon interviews for additional evidence of compliance with provision (d), as all staff members and residents explained that residents are consistently provided access to their attorneys and may speak to them privately. Since the facility demonstrated compliance with all provision, JCC - St. Anthony meets the requirements of this standard.

Recommendation:

1. Although youth demonstrated general knowledge of outside victim advocacy services, none could name the entity that would provide this service. Provide additional education to the youth regarding the advocacy services available through the Family Crisis Center.

Standard 115.354: Third-party reporting

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

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. IDJC public website: <http://www.idjc.idaho.gov>
2. Campus Parent Handbook

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(a): The IDJC Campus Parent Handbook indicates that third-party reports are accepted. The IDJC public website homepage provides information about reporting suspected abuse and states individuals may “contact IDJC by selecting Contact Us below, or by contacting law enforcement in the jurisdiction of the facility. All reports are taken seriously and investigated as outlined in the PREA standards.”

Summary of Findings:

The auditor compared IDJC policy and the public website to the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall have a method to receive third-party reports. Since policy contains this information, compliance with this provision is supported. For additional evidence, the auditor visited the agency website page, which informs the public about and contain links to reporting options. The auditor determined St. Anthony meets the requirements of provision (a), and thus this standard.

Corrective Action: None

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

115.361 (e)

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?
 Yes No
- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? Yes No
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? Yes No

115.361 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. IDJC Policy 614 - Investigations
4. IDJC Policy 910 – Investigations – Administrative
5. IDJC Juvenile Notice of Limited Confidentiality form

Interviews:

1. Superintendent

2. Compliance Manager
3. PREA Compliance Coordinator
4. Nurse Manager
5. Random staff

Observations: No observations relative to this standard were required.

(a): IDJC policy requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring at an IDJC juvenile corrections center, staff will immediately contact their supervisor or if not available, the designee or duty officer. Interviews with random staff members demonstrated their knowledge of their reporting responsibilities under facility policy.

(b): IDJC policy requires that IDJC will comply with all mandatory reporting laws and states 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. Interviews with staff indicate they are aware of and understand mandatory reporting laws.

(c): IDJC policy requires that all staff will respect the dignity and privacy of those involved in an allegation of sexual abuse, including the alleged offender, alleged victim, and any witness. Incidents of sexual abuse are not topics for casual conversation with staff or juveniles. Policy requires that staff shall not reveal information related to an allegation of sexual abuse to anyone, including other staff, except for purposes of reporting as outlined below or to the extent necessary to assist in an investigation, to provide medical or mental health treatment, or for other security purposes. Interviews with staff demonstrated they understand the requirements for the handling of sensitive youth information. They said they received the information at least annually during training.

(d): IDJC policy requires that all staff members, including medical and mental health staff, follow the reporting requirements pursuant to the provisions above. Interviews with medical and mental health care staff confirmed compliance with this standard, as they stated they are mandatory reporters. They also explained that residents receive information during intake outlining the limits of confidentiality. The IDJC Juvenile Notice of Limited Confidentiality form includes information about the limits of confidentiality and lists the disclosures that must be reported. The form contains fields where the resident signs and dates the form to indicate his or her receipt and understanding of the information. The form also contains fields where staff members sign and date as witnessing the resident's receipt as well as a field where staff members sign as witnessing the resident's refusal to sign the document.

(e): IDJC policy does not address this provision; however, the Superintendent and Compliance Manager said if reports pursuant to this provision are received, proper notifications are made to supervisory staff members, law enforcement as required, the resident's parents, or the resident's case worker if the resident is in health and welfare custody.

(f): IDJC policy requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring at an IDJC juvenile corrections center, staff will immediately contact their supervisor or if not available, the designee or duty officer. IDJC policy regarding investigation requires that all allegations are promptly and thoroughly investigated unless they are clearly criminal, in which case, the allegation would be referred to law enforcement. The IDJC policy pertaining to administrative investigations indicates that when a supervisor receives a complaint, the Division Administrator may conduct an initial inquiry to assist the Director in determining whether the matter should be referred to the Deputy Attorney General for investigation. If the complaint is an allegation under the PREA, the

Division Administrator contacts the Deputy Attorney General and Compliance Coordinator and assigns the initial inquiry to the facility Compliance Manager.

Summary of Findings:

The auditor compared IDJC policies to the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall require staff to report any knowledge, suspicion, or information regarding sexual abuse, retaliation, and neglect; b) the agency shall require staff to comply with mandatory reporting laws; c) staff shall not reveal information regarding sexual abuse incidents other than to the extent necessary; d) medical and mental health staff must report sexual abuse to supervisors, state and local agencies where required by mandatory reporting laws and inform residents of the limitations of confidentiality; e) upon receiving a sexual abuse allegation, the facility head or designee must report to appropriate agencies, and the resident's parents, caseworker, legal guardian, or legal representative; and f) the facility shall report sexual abuse allegations to investigators.

The auditor and concluded that each element is addressed in IDJC policies, which supports compliance with provisions (a) – (f). Additional evidence relied upon to determine compliance with provisions (a) and (b) was based upon interviews with staff members who communicated an understanding of their reporting duties. Compliance with provision (c) was determined through interviews, during which staff members communicated their understanding of protecting information related to sexual abuse reports. Evidence for provision (d) was based on staff medical and mental health staff members' understanding of mandatory reporting laws. Additional evidence was supported after reviewing the IDJC Juvenile Notice of Limited Confidentiality form. Compliance with provisions (d) and (e) was also based on interviews, during which staff members articulated knowledge of their reporting duties and understood to whom they would report any information regarding sexual abuse. The auditor also reviewed incident reports and investigative reports and concluded that since verbal and written allegations of sexual abuse were reported and subsequently investigated, compliance with provision (f) was proven. Since the facility demonstrated compliance with each provision, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documents and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance

Interviews:

1. Superintendent
2. Compliance Coordinator
3. Random staff

Observations: No observations relative to this standard were required.

(a): IDJC policy requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring at an IDJC juvenile corrections center, staff will ensure the safety of the alleged victim and take steps to separate the alleged offender, alleged victim and any witnesses. Policy also stipulates that separation does not mean isolation, unless other less restrictive measures to ensure the safety of those involved have failed. The PAQ indicates there have been no instances of residents being subject to substantial imminent risk of sexual abuse in the past 12 months. All staff members interviewed were able to explain precautions that would be taken to protect a resident at risk of imminent sexual abuse. These included immediately separating the alleged victim and abuser and beginning mental health services. During random staff member interviews, additional actions they described that could be taken were calling for additional staff members, placing the victim next to a staff member, and making proper notifications to supervisory staff members and the Compliance Manager.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) when an agency learns a resident is at risk of imminent sexual abuse, immediate action to protect the resident must be taken. The auditor reviewed policy and determined this provision is addressed. Since an incident of this type did not occur during the audit period, the auditor relied on staff members' responses during interviews and assessed their knowledge regarding the actions that would be taken if this should occur. Staff members communicated an understanding of these actions per this standard and the facility coordinated response plan and were able to articulate specific and immediate actions they would take. The auditor determined the facility meets the requirements of provision (a), and thus this standard.

Corrective Action: None

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documents and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 614 – Investigations

3. IDJC Policy 613 – PREA Compliance
4. Investigation summaries

Interviews:

1. Superintendent
2. Agency Head

Observations: No observations relative to this standard were required.

(a): IDJC policy requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident that is reported to have occurred at another facility, 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. The auditor's interview with the Agency Head confirmed his knowledge of this requirement. The facility reported there was one allegation of this type in the past 12 months. The allegation involved a resident at St. Anthony who reported sexual contact with a resident while placed at another IDJC facility. Documentation provided that supports compliance with this provision included correspondence between the two facilities, results of the investigation, factors considered during the investigation, and actions taken as a result of the investigation, which included staff training and reminders and a slight change in procedures.

(b): IDJC policy requires that the notification will be provided as soon as possible but no later than 24 hours after receiving the allegation, which exceed the 72-hour requirement of this provision.

(c): One allegation was received, and the appropriate notification was made.

(d): IDJC policy requires that all allegations of sexual abuse and harassment received, including third-party and anonymous reports, are investigated promptly, thoroughly, and objectively, to the extent possible.

Summary of Findings:

The auditor reviewed IDJC policies, correspondence between two IDJC facilities, and investigation summaries and compared these documents to the elements of this standard and the PREA Audit Tool, which require that: a) upon receiving an allegation of sexual abuse that occurred at another facility, the facility head notifies the facility head or appropriate office where the alleged abuse occurred; b) the notification shall be provided immediately but no later than 72 hours after receiving the allegation; c) the notification shall be documented; and d) the facility head or agency office shall ensure the allegation is investigated.

One allegation of this type was reported during the audit period and included proper notification from one IDJC facility to another, investigation notes, and actions taken, which supports compliance (a), (b), and (c). The auditor determined that each provision except is addressed in policy, and exceeds the requirements of provision (b). The interview responses of the Superintendent and the Agency Head confirmed their knowledge of documentation and reporting responsibilities when a sexual abuse allegation is received from another facility. The facility demonstrated compliance with all provisions and exceeds the requirements of provision of (b); thus, the auditor determined the facility exceeds the requirements of this standard.

Corrective Action: None

Standard 115.364: Staff first responder duties

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

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
 Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.364 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documents and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. St. Anthony Coordinated Response Plan

Interviews:

1. Security staff and non-security staff first responder
2. Random staff

Observations: No observations relative to this standard are required.

(a): IDJC Policy 613 requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring in the facility, a staff member will ensure the safety of the alleged victim, take steps to separate the alleged offender, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence, and if the abuse occurred within a time frame that still allows for evidence collection, the staff member shall request that no actions are taken by the alleged victim or abuser that could destroy physical evidence. The facility reported that in the previous 12 months, there were 11 allegations that a resident was sexually abused. Of the 11, the first responder separated the alleged victim and abuser seven times. Staff members not notified within a time period that would allow for the collection of physical evidence in any of the 11 incidents. During her interview, the security staff and non-security staff first responder stated she would separate the victim from the abuse, request assistance from another staff member in keeping them separated, protect the scene and evidence, ensure the victim does not destroy evidence (showering, washing hands, brushing teeth, washing clothes), notify the duty officer and PREA Compliance Manager, notify medical and mental health care staff, and write an incident report.

The coordinated response plan expands the first responder duties and provides detailed instructions on actions to be taken including ensuring the safety of the victim, separating all parties involved, offer medical and mental health services, notify the duty officer and the PREA Compliance Manager, protecting the scene, preserving physical evidence, complete required documentation, ensure confidentiality of the investigation, and follow directives from law enforcement, the Compliance Manager, and the Superintendent or designee.

Corrective actions and responses to incidents of alleged sexual abuse or harassment are documented in each incident review. As noted in Standard 115.352, initial reviews and corrective actions must be completed within 48 hours. Actions noted in the incident review reports included providing medical and mental health care, changing routines to allow for increased supervision, revising practices, placing residents on safety plans, notifying law enforcement, informing relevant staff members, moving a resident's bed to be closer to staff members, and separating residents involved in the incident.

(b): IDJC policy outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused. The PAQ indicates there were zero instances where a non-security staff member was the first responder to an allegation of sexual abuse and; therefore, circumstances in which a non-security staff member needed to request that residents not take actions that would destroy physical evidence. In a follow-up question in the issues log, the facility reported that all staff members are considered first responders. During interviews with random staff members, they could articulate their first responder duties, which would include separating the alleged victim and alleged abuser, protecting the scene and any physical evidence, reporting the incident to supervisors, and documenting the incident.

Summary of Findings:

The auditor reviewed IDJC policy and the facility coordinated response and compared these documents to the elements of this standard and the PREA Audit Tool, which require that: a) upon learning that a resident was sexually abused, the first responder must separate the alleged victim and abuser, preserve the scene and collect evidence, collect physical evidence if the abuse occurred within a time period that this evidence may be collected, and ensure physical evidence is protected; and b) if the first responder is not a security staff, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. The auditor determined that IDJC policy and the coordinated response plan contain each of these elements, which supports compliance with provisions (a) and (b). Interview responses revealed additional evidence of compliance, as staff members communicated an understanding of the actions they would take following an allegation of sexual abuse. Since the facility demonstrated compliance with both provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documents and Policy Reviewed:

1. Completed PAQ
2. Coordinated response plan

Interviews:

1. Superintendent

Observations: No observations relative to this standard were required.

(a): The facility maintains a written plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, Compliance Manager/PREA Investigator, law enforcement, medical and mental health staff, facility leadership, and facility Superintendent. The plan also includes the contact information for the Compliance Manager during and not during business hours, law enforcement, the Idaho Department of Health and Welfare Child Abuse and Neglect, the victim advocacy provider, and the local hospital that would provide a forensic examination if needed. In his interview, the Superintendent demonstrated knowledge of the details in policy and the coordinated response plan.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall develop a written institutional plan to coordinate actions in response to an incident of sexual abuse. The auditor determined the facility policy contains details regarding this provision. Additional support of compliance was determined following a review of the the facility's coordinated response plan, which includes actions to be taken by various staff members. During his interview, the Superintendent demonstrated comprehension of the plan. The auditor concluded that St. Anthony meets the requirements of provision (a), and thus meets the requirements of this standard.

Corrective Action: None

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

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

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual

abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documents and Policy Reviewed:

1. Completed PAQ

Interviews:

1. Agency Head

Observations: No observations relative to this standard are required.

(a): The agency meets the requirements of this subsection as IDJC does not enter into collective bargaining agreements that would limit their ability to remove alleged staff sexual abusers from contact with any youth pending an investigation determination. During his interview, the Agency Head stated that the IDJC does not engage in collective bargaining. The PAQ indicates this information as well.

(b): The auditor is not required to audit this provision.

Summary of Findings:

This standard and the PREA Audit Tool require that: a) the agency shall not enter into a collective bargaining agreement that limits the agency's ability to remove alleged abusers from contact with residents pending the outcome of investigation or disciplinary actions. Provision (b) is not required to be audited. The auditor relied upon the PAQ and the interview with the Agency Head. Both indicated IDJC

does not engage in collective bargaining, which supports compliance with provision (a), and thus, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.367 (b)

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

115.367 (c)

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

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documents and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. IDJC Policy 307 – Harassment and Discrimination
4. Sexual Abuse/Harassment Retaliation Monitoring form
5. St. Anthony Coordinated Response Plan

Interviews:

1. Agency Head
2. Superintendent
3. Compliance Manager (staff member who monitors for retaliation)
4. Residents who reported a sexual abuse

Observations: No observations relative to this standard are required.

(a): IDJC policy requires the facility to monitor for and respond to acts of retaliation. The staff member responsible for this is the PREA Compliance Manager. The Harassment and Discrimination policy states all complaints of harassment, discrimination, and retaliation are promptly conducted, and all employees are protected from coercion, intimidation, retaliation, interference, or discrimination for filing a complaint or assisting in an investigating. The facility coordinated response plan indicates one of the actions to be taken after an allegation is to monitor for retaliation per the PREA standards on the retaliation monitoring form.

(b): IDJC policy requires multiple protection measures to be put into place for juvenile victims. These include housing changes, removal of the alleged abuser, and emotional support services. Staff members were able to articulate actions utilized to protect youth and staff members and monitor for retaliation. The Superintendent and Agency Head explained that monitoring for retaliation is conducted after allegations of sexual abuse, and the Compliance Manager said measures taken include housing changes, face-to-face check ins, and daily log documentation. The auditor reviewed the monitoring form, which includes fields to note basic information, the reason for the monitoring, and weekly actions and observation. During interviews, the residents who reported a sexual abuse said they felt safe and did not fear retaliation after submitting their report. Residents are not placed in isolation; therefore, interviews with residents in isolation were not conducted.

(c): The Compliance Manger is the staff member responsible for monitoring for retaliation. During her interview, she was knowledgeable about the duty to monitor for retaliation for at least 90 days and said this time would be extended if needed, as there is no maximum time for monitoring efforts. She stated monitoring efforts have been extended past 90 days on several occasions. The monitoring form also supports compliance with the 90-day timeline. The PAQ indicates there have been zero instances of retaliation during the previous 12 months.

(d): IDJC policy requires that staff members conduct periodic checks of the alleged victim. The monitoring forms indicate these checks are conducted weekly. The Compliance Manager who is the staff member responsible for monitoring stated there is no maximum length of time a youth would be

monitored. She said status checks would be conducted at least once per week but are typically more frequent, as she informally encounters residents while in the facility.

(e): IDJC policy stipulates that multiple protection measures may be taken including housing changes or transfers for juvenile victims or abusers, removal of alleged staff or juvenile abusers from contact with victims, and emotional support services for juveniles or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The Superintendent and Agency head demonstrated their knowledge of retaliation monitoring requirements during their interviews and said monitoring could occur for residents as well as staff members.

(f): The auditor is not required to audit this provision.

Summary of Findings:

The auditor reviewed IDJC policies, the monitoring retaliation form, and the coordinated response plan and compared these documents to the elements of this standard and the PREA Audit Tool, which require that: a) the agency establishes policy to protect residents and staff from retaliation, b) the agency shall use multiple protection measures, c) the agency shall monitor for retaliation for at least 90 days, d) monitoring shall include periodic status checks, and e) if any individual expresses fear of retaliation, the agency takes steps to protect the individual. The auditor is not required to audit provision (f).

The auditor determined that IDJC policies address each provision, which demonstrates compliance with provisions (a)-(f). Evidence of compliance with provision (a) includes the facility's designation of the PREA Compliance Manager as the staff member who is responsible for retaliation monitoring. Evidence of compliance with provisions (b) – (e), was determined after reviewing interview responses. The Compliance Manager communicated an understanding of her monitoring duties and the required timeline during her interview. The Compliance Manager, Superintendent, and Agency Head described actions that would be utilized to protect youth or staff who feared retaliation. Since the facility demonstrated compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

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

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. IDJC Policy 604 – Special Management Interventions

Interviews:

1. Superintendent
2. Staff who supervise youth
3. Medical and mental health care staff

Observations: Since the facility does not utilize isolation, observations pursuant to this standard were not conducted during the audit.

(a): IDJC policy requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring at an IDJC juvenile corrections center, staff will ensure the safety of the alleged victim and take steps to separate the alleged offender, alleged victim and any witnesses. Policy also stipulates that separation does not mean isolation, unless other less restrictive measures to ensure the safety of those involved have failed. A second policy pertaining to interventions details circumstances when a resident is placed in isolation only as a last resort when less restrictive measures are inadequate to keep the resident safe. When residents are segregated, policy requires that residents have access to reading and writing materials, medical and mental health care, the grievance system, and recreation/exercise outside of his or her room. The PAQ indicates there were no instances of resident being placed in isolation because they alleged to have suffered sexual abuse. The Superintendent and medical/mental health care staff stated isolation is not used at St. Anthony.

Since isolation is not used, the Staff who Supervise Residents in Isolation and Residents in Isolation interview protocols were not used during the audit.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) any segregated housing used to protect a resident alleged to have suffered sexual abuse shall be subject to the requirements in Standard 115.342. The auditor's determination of compliance with this provision was based on policy review and interview responses. The policy

contains details regarding provision (a), and staff members reported that this type of segregation is not used. No residents were placed in isolation pursuant to this standard during the facility inspection. Since St. Anthony is compliant with provision (a), the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

115.371 (b)

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

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.371 (d)

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

115.371 (e)

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

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
 Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.371 (h)

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

115.371 (i)

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

115.371 (j)

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

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 910 - Investigations - Administrative
3. IDJC Policy 614 – Investigations – PREA
4. IDJC Policy 613 –PREA Compliance
5. IDJC Policy 324 - Ethic's & Standards of Conduct
6. Criminal and administrative investigative reports
7. Substantiated case referred for prosecution
8. Training records for investigators

Interviews:

1. Superintendent
2. PREA Compliance Coordinator
3. PREA Compliance Manager
4. Random staff
5. Investigative staff
6. Residents who reported a sexual abuse

Observations: Since the facility does not utilize isolation, no isolation cells/rooms could be observed during the facility inspection.

(a): IDJC Policy 910 requires that investigations will be conducted in an impartial, objective, confidential, and expeditious manner. Policy also states that a complaint may originate from any source

including from an anonymous source. IDJC Policy 614 states that all allegations received, including third-party and anonymous reports, are investigated promptly, thoroughly, and objectively, to the extent possible.

Six police reports were provided during the pre-audit phase to demonstrate compliance with this provision. The reports include details of the allegation, suspect and victim information, notification of Miranda rights, interviews conducted, statements collected, video review, referrals to a child advocacy center, findings, contact with the facility, referrals to the county prosecutor, and whether charges were filed.

Two non-criminal investigative reports were also provided during the pre-audit phase. These contained interview forms with the alleged victim and perpetrator information, the PREA Compliance Manager's interview notes, and supporting evidence such as video review. The facility provided the corresponding incident reviews and notifications of the outcome to the juveniles involved. One non-criminal case was substantiated, and the other was unsubstantiated.

During his interview, the investigator said if the report is live, the investigation would begin immediately, and if the allegation did not require immediate actions, the investigation would begin the same or next day. He stated the same actions would be taken when third party or anonymous reports were received. He also said he would notify the PREA Compliance Manager in any of these instances.

(b): IDJC policy requires that it will use investigators who have taken at least one basic investigative training course approved by the Deputy Attorney General before being solely responsible for an investigation. In addition, each investigator will attend investigator meetings or in-house trainings whenever possible. The investigator demonstrated his understanding of interviewing residents, evidence collection in confinement settings, and criteria needed to substantiate a case.

(c): IDJC Policy 910 requires that investigators provide all facts, documentation, statements and evidence gathered during the initial inquiry to the Deputy Attorney General upon completion of the initial inquiry. The non-criminal and criminal case details indicate evidence including video reviewed and statements were gathered and considered when determining findings.

IDJC Policy 910 contains a link to the records retention and destruction schedule; however, this link could not be accessed. The policy does state that all written, recorded and other documents shall be saved in the electronic Deputy Attorney General folder in the IDJC Data Center under the investigator's name with an investigative file name. The QIS Handbook stipulates that 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 ten 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.

(d): IDJC Policy 614 stipulates that investigations will not be terminated because the source of the allegation recants the allegation. The investigator supported compliance with this standard stating that an investigation would not end due to an allegation being recanted.

(e): IDJC policy does not address conducting compelled interviews, as these types of interviews would be conducted by the sheriff department if the allegation supports criminal prosecution. However, policy does stipulate that staff members are compelled to cooperate with any investigation. The facility investigator said any prosecutable crime would be referred to law enforcement for compelled

interviews. No investigative records indicated compelled interviews were conducted during the course of the investigation.

(f): IDJC Policy 614 states that the credibility of individuals being interviewed is not determined by their status as a staff or juvenile and is assessed on an individual basis. The policy also states no polygraph or truth-telling device will be used. The interview with the investigator confirmed understanding of and compliance with this practice.

(g): IDJC Policy 614 outlines the responsibilities of the review team and items they must consider when making determinations, which includes whether the incident occurred due to staffing, policy deficits. Additionally, the investigative reports and incident review forms provided during the pre-audit phase indicate investigations conducted by the PREA Compliance Manager are thorough and staff actions are considered in making determinations.

(h): IDJC policy does not address how criminal investigative are documented. However, the police reports provided during the pre-audit phase demonstrate criminal investigations are documented and include descriptions of evidence collected during the investigation. The investigative staff member said criminal investigations are conducted by law enforcement.

(i): IDJC Policies 614, 910, and 613 indicate allegations involving clearly-criminal actions, or those where an initial investigation reveals evidence supporting criminal prosecution, are referred to the appropriate law enforcement agency for criminal investigation. The PAQ indicated there was one substantiated allegation that was referred for prosecution. These referrals are documented in the police reports provided during the pre-audit phase, and state that although the referral was made, the prosecutor declined to file charges. The investigative staff member stated cases are not referred for prosecution at the facility level.

(j): The IDJC QIS Handbook indicates the Agency PREA Coordinator shall retain, in a secure location, all reports related to PREA allegations as long as the alleged abuser is incarcerated or employed by the agency, plus ten years, unless the abuse was committed by a juvenile and applicable law requires a shorter period of retention.

(k): IDJC Policy 614 stated that an investigation is not closed based on the departure of the alleged abuser or victim from a facility, IDJC custody, or employment. The investigator said the investigation would continue regardless if the alleged abuser or victim is no longer employed or placed with the facility or agency.

(l): The auditor is not required to audit this provision.

(m): IDJC Policy 614 requires that the IDJC cooperates fully with the law enforcement investigators and maintains contact in order to remain informed about the progress of the investigation. During interviews, the Superintendent, Compliance Manager, and Compliance Coordinator stated that the investigators would keep them informed.

Summary of Findings:

The auditor reviewed IDJC policy, criminal and administrative investigative reports, cases referred for prosecution, and training records of investigators and compared these documents to the elements of this standard and the PREA Audit Tool, which require that: a) the agency conducts thorough and prompt investigations; b) investigators must have specialized training; c) investigators shall gather

evidence and shall review prior complaints involving the suspected perpetrator; d) the investigation continues if the complainant recants the allegation; e) the agency conducts compelled interviews only after consulting with prosecutors; f) the credibility of the alleged victim shall be assessed on a case-by-case basis, and no polygraphs or truth-telling devices are used as a condition of continuing the investigation; g) administrative investigations shall include the consideration of staff actions and shall be documented in written reports; h) criminal investigations shall be documented in written reports; i) substantiated allegations that appear criminal shall be referred for prosecution; j) the agency maintains all written reports as long as the alleged abuser is incarcerated or employed by the agency plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; k) the departure of the alleged abuser or victim from the facility or from employment shall not provide a basis for terminating an investigation; and m) the facility cooperates with outside investigators. Provision (l) is not required to be audited.

The auditor determined that the IDJC policy addresses each of these provisions, which supports compliance with provisions (a) – (m). Compliance with provision (b) was based on policy and information gathered during interviews. Compliance with provision (d) was determined by reviewing investigative reports including one that was referred for prosecution. Compliance with provision (f) was based on the investigator’s responses during interviews. Compliance with provisions (a) – (m) was based on interview responses, which revealed an understanding of the requirements of each provision. Since policy, interview responses, and investigative reports demonstrated compliance with each provision, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documentation and Policy Reviewed:

1. IDJC Policy 614 – Investigations
2. Investigative reports

Interviews:

1. PREA Compliance Manager/Investigator

Observations: No observations relative to this standard are required.

(a): IDJC policy stipulates that “the investigation is closed when the PREA Incident Review Team has reviewed the DJC-276 and supporting information, as applicable, and, based on the preponderance of the evidence provided, makes a determination whether the allegation is substantiated, unsubstantiated, unfounded, considered non-abusive contact, or does not fit the definition of PREA incident.” The interview with the Compliance Manager who acts as the facility investigator confirmed her knowledge of the required standard of proof. The investigative reports and corresponding notifications containing dispositions indicate the standard of proof pursuant to this provision is utilized.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency standard to substantiate a case is a preponderance of the evidence. Policy addresses this standard; the investigator communicated an understanding of this provision; the investigative reports indicate the standard of proof is a preponderance of the evidence; therefore, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

115.373 (d)

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 614 – Investigations – PREA
3. IDJC Form 262 – PREA Incident Review

Interviews:

1. Superintendent
2. Investigative staff member

Observations: No observations relative to this standard were required.

(a): IDJC policy requires that the juvenile making the allegation receives a copy of Section D of the agency form notifying them of the investigation findings, when the finding is substantiated, unsubstantiated or unfounded. During their interviews, the investigator demonstrated knowledge regarding conducting investigations. He stated the PREA Compliance Manager notifies residents to the outcomes of all investigations.

(b): In the past 12 months, 11 criminal and/or administrative PREA-related investigations have been conducted, and 11 notifications to residents were made. The facility provided multiple resident notifications of substantiated, unsubstantiated, or unfounded investigations. The notifications are documented on the PREA Incident Review Form and include the outcome of the investigation, the resident's signature indicated he or she received the notification, and the date the notification was received.

(c): IDJC policy requires that the juvenile who made the allegation be informed of the outcome of the investigation when the finding is substantiated, unsubstantiated or unfounded, which exceeds the requirement of this provision. The PREA Incident Review form includes fields to indicate whether the staff member is no longer employed with IDCJ, has been indicted on a charge related to sexual abuse within the facility, or has been convicted on a charge related to sexual abuse within the facility. There were no cases in which a staff member was confirmed to have violated a rule, thus no documentation of complaints or notifications could be reviewed.

(d): IDJC policy requires that the juvenile who made the allegation be informed of the outcome of the investigation when the finding is substantiated, unsubstantiated or unfounded, which exceeds the requirement of this provision. The PREA Incident Review form includes fields to indicate whether the juvenile abuser has been referred for prosecution or adjudicated on a charge related to sexual abuse. The facility provided notifications, which included the investigation finding, signature of the juvenile, and the date the juvenile was informed. The forms provide additional evidence of the facility exceeding the requirements of this provision.

(e): IDJC policy requires that the findings of the investigation are documented on the agency PREA Incident Review form. The PAQ indicates 11 investigations were conducted, five of which were documented. The five documented notifications were for investigations resulting in findings of substantiated, unfounded, or unsubstantiated. The notifications not documented were for investigations that resulted in findings of not PREA-related and non-abusive contact.

(f): The auditor is not required to audit this provision.

Summary of Findings:

The auditor reviewed IDJC policy and PREA incident review forms and compared them to the elements of this standard and the PREA Audit Tool, which require that: a) following an investigation, the agency shall inform the resident of the outcome; c) the agency informs the resident when the staff member is no longer posted in the resident's unit, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility; d) following a resident's allegation that he or she has been sexually abused by another resident, the agency informs the alleged victim whenever the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility; and e) notifications are documented. Provision (e) was not audited, as the OIG is considered an outside investigating entity. The auditor determined IDJC policy exceeds the requirements of addresses provisions (a), (b), (c), and (d). The notifications provided indicated the facility notifies residents of investigations resulting in a findings of substantiated, unfounded, or unsubstantiated, not only those with findings pursuant to provisions (b), (c), (d). This practice exceeds the requirements of this standard. Since the facility policy and practice exceed the requirements of each audited provision, the auditor determined St. Anthony exceeds the requirements of this standard.

Corrective Action: None

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance

Interviews: No interviews protocols are directly related to this standard.

Observations: No observations relative to this standard are required.

(a): IDJC policy states that termination shall be the presumptive disciplinary sanction for staff members who engage in sexual abuse, subject to Idaho rules and statutes and IDJC policies regarding due process. Policy also states that resignations in lieu of terminations shall be reported to law enforcement agencies and any relevant licensing bodies, unless the activity was clearly not criminal.

(b): IDJC policy requires that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. In the past 12 months, the facility reported that zero staff members have violated the IDJC policy on sexual abuse or sexual harassment.

(c): Although policy does not include specific language pursuant to this provision, the Compliance Coordinator said although staff rule violations and resulting disciplinary sanctions are rarely required, “When there is an issue where a staff has violated policy, typically a juvenile supervision policy, the exact nature of the violation is taken into consideration when the response is formulated. Factors including the egregiousness of the violation, past responses with other staff when such a violation has occurred, repeat offenses, & other such factors are taken into consideration.”

(d): IDJC policy requires compliance with mandatory reporting laws. Policy indicates 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.” The PAQ indicates there have been zero incidents of staff members reported to law enforcement or licensing boards for violating the agency’s sexual abuse or sexual harassment policy.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) staff shall be subject to disciplinary sanctions up to and including termination for violations of PREA policy, b) termination is the presumptive sanction for sexual abuse, c) sanctions are commensurate with the nature of the violation, and d) terminations for PREA violations shall be reported to law enforcement agencies.

Policy and interview responses address all provisions, which evidences compliance with this standard; thus, St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance

Interviews:

1. Superintendent

(a): IDJC policy states that termination shall be the presumptive disciplinary sanction for volunteers and contractors who engage in sexual abuse, subject to Idaho rules and statutes and IDJC policies regarding due process and will be reported to law enforcement agencies and any relevant licensing bodies, unless the activity was clearly not criminal. The PAQ indicates that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of resident.

(b): IDJC reported that facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. During his interview, the Superintendent stated if a contractor or volunteer violated the agency sexual abuse policy, the facility would take remedial measures prohibiting further contact with residents.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) contractors or volunteers who violate PREA policy shall be prohibited from contact with residents and reported to law enforcement agencies if the activity was criminal and b) the facility shall take appropriate remedial measures in the case of any other violation of agency sexual abuse or harassment policies by a contractor or volunteer.

Since the facility reported no instances of volunteer or contractor PREA violations, the auditor determined compliance based on policy review and interview responses. IDJC policy addresses both provisions. The Superintendent's responses provided additional evidence of compliance, as he communicated knowledge of actions that would be taken following a PREA violation by a contractor or volunteer. Since compliance was demonstrated with both provisions, the auditor determined that St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? Yes No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? Yes No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? Yes No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance

Interviews:

1. Superintendent
2. Medical and mental health staff

Observations: No observations relative to this standard are required.

(a): IDJC policy states that disciplinary actions may be taken “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 PAQ indicates there were three instances of resident-on-resident sexual abuse that occurred and zero criminal findings of guilt during the last 12 months.

(b): IDJC policy requires that “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.” The Superintendent said sanctions could include criminal charges if applicable but the youth would not be held in isolation as punishment. The facility reported that in the past 12 months, there have been no resident placed in isolation as a disciplinary sanction for resident-on- resident sexual abuse.

(c): IDJC policy requires that the disciplinary process consider whether a youth’s mental disability or mental illness contributed to his or her behavior. During his interview, the Superintendent said the youth’s mental illness would be taken into consideration when considering sanctions.

(d): IDJC policy states that the facility will provide medical and mental health services to identified victims and states these services are provided to the alleged offender or victim. The mental health care

staff member interviewed said the facility offers services to treat resident victims as well as perpetrators. She stated participation in treatment is not a required to progress in the program.

(e): IDJC policy requires that a juvenile will only be disciplined for sexual contact with staff upon a finding that the staff member did not consent to such contact. The facility reported that there have been examples of this during the last 12 months; therefore, records could not be reviewed.

(f): IDJC policy states “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.”

(g): IDJC policy prohibits all sexual activity between residents and states that “incidents of sexual activity, whether consensual or nonconsensual; threats to engage in nonconsensual sexual activity; and solicitation to engage in sexual activity are recognized problems that can occur in juvenile correctional facilities in the United States.”

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) residents may be subject to sanction only pursuant to a formal disciplinary process; b) sanctions shall be commensurate with the circumstances of the abuse committed, and the facility must provide specific services to residents who receive sanctions resulting in isolation; c) the disciplinary process shall consider a resident’s mental disability when determining sanctions; d) if the facility offers therapy, counseling, and other interventions, the facility shall consider whether to offer the services to the offender, and the agency may require participation in such interventions as a conditions of access to rewards-based incentives but not as a condition to access to general programming; e) the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did no consent; f) reports made in good faith shall not constitute false reporting; and g) the agency may prohibit all sexual activity between residents, may discipline resident s for such activity, and may not deem the activity sexual abuse if it determines that the activity is not coerced.

The auditor determined that IDJC policy addresses each provision, which demonstrates compliance with all provisions. Staff members’ interview responses confirmed their knowledge of the disciplinary and sanction process. No residents were placed in isolation. Since the facility demonstrated compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

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

115.381 (b)

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

115.381 (c)

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

115.381 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 404 – Observation and Assessment Evaluations
3. IDJC Policy 613 – PREA Compliance
4. Staffing notes for a resident who disclosed prior sexual abuser
5. Screen shot to evidence the resident's counseling sessions
6. IDJC Juvenile Notice of Limited Confidentiality form

Interviews:

1. Medical and mental health care staff
2. Residents who reported prior sexual abuse during screening

Observations:

1. All files are stored electronically in the Idaho Juvenile Offender System (IJOS)

(a): IDJC policy requires that within three calendar days of a residents' arrival, he or she is administered the Risk of Sexual Victimization/Perpetration Screener by a Clinician. If the resident discloses prior abuse, the clinician documents the disclosure on the screener and a referral is made for mental health care services. Documentation was provided showing a resident's disclosure of sexual victimization, the subsequent staffing notes, and approval for the referral for clinical services. A screen shot was uploaded that indicated the resident received multiple individual counseling sessions. The staff member responsible for screening for risk of sexual abusiveness or victimization said if a resident discloses prior abuse, the disclosure is documented on the screening tool, a meeting is arranged within 24-48 hours to address the resident's needs, and services provided within in 24-48 hours.

The Compliance Manager noted in the PAQ that "secondary documentation of mental health services is located in the juveniles Observation & Assessment report, in the IJOS contact notes &/or on a Notification of Disclosure (IDJC 131) form. A sample of the Notification of Disclosure form was reviewed prior to the audit.

Five residents who disclosed prior abuse during the screening were interviewed. All said they were asked if they would like to speak to a counselor. Several said they did not recall when or if they received counseling, others said they received counseling several weeks later, and others said they declined the services.

(b): IDJC policy states that "IDJC will ensure that medical & mental health needs of the alleged offender or victim are met." The PAQ indicates that 100% of residents who previously reported sexual perpetration received a follow-up meeting with a mental health care staff member. During interviews,

the staff member responsible for the screening stated that follow-up services are provided within 24-48 hours. Secondary materials are discussed in the provision above.

(c): As noted above in Standard 115.341 (e), resident files are securely stored. Records are electronically stored in the IJOS database. The intake staff member said information from the risk screening is restricted to clinicians and supervisors. The Compliance Manager reiterated that the information gained during the screening is restricted to clinicians, supervisors, and the Compliance Manager. The Compliance Coordinator said the screenings are completed and pertinent staff members are informed of the risk level. He said the information is stored in the IJOS system, which is only accessible by clinical-level staff members. No confinement records were reviewed, as St. Anthony does not place residents in confinement.

(d): All residents sign and date the IDJC Juvenile Notice of Limited Confidentiality form, which explains the facility's limits of confidentiality. A staff member also signs and dates the form as a witness. Interviews with mental health staff indicated that informed consent is obtained.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) if the intake screening indicates the resident has experienced prior sexual victimization, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; b) if the screening indicates the resident has previously perpetrated sexual abuse, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; c) any information related to sexual abuse or victimization shall be strictly controlled; and d) medical and mental health practitioners shall obtain informed consent before reporting information about prior victimization that did not occur in an institution, unless the resident is under the age of 18.

IDJC policy addresses each provision, which supports compliance with provisions (a) – (d). Evidence demonstrating compliance with provisions (a) and (b) included a referral to counseling services based on screening information and documentation that multiple counseling sessions took place. Residents said they received mental health services within several weeks. Compliance with provision (c) was demonstrated during interviews when staff members explained the limited access to resident screening information. Additional compliance was evidenced during the facility inspection when the auditor noted the area in which the files were stored. The auditor determined additional compliance with provision (d) during an interview with the medical and mental health staff who communicated an understanding of informed consent. Since the facility demonstrated compliance with all provisions, the auditor determined that St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

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

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 835 – Sexual Assault
3. IDJC Policy 613 – PREA Compliance

4. St. Anthony Coordinated Response Plan
5. Medical mental health records

Interviews:

1. Medical and mental health care staff
2. Residents who reported sexual abuse

Observations:

1. Facility clinic

(a): The PAQ says information relevant to this standard would be more easily reviewed on site at the clinic but here's what I gathered with all the stuff they sent – it's enough to determine compliance I think. The facility employs on-site medical and mental health care staff members who provide services as needed. As noted in Standard 115.321, IDJC policy states that medical services pertaining to sexual assault, including forensic examinations, are provided to residents who require these services. The alleged victim would be referred to a community facility and an IDJC staff member would accompany and supports the juvenile through the forensic medical examination process. Mental health treatment is provided by licensed health care professionals while the juvenile is in IDJC custody."

As described in Standard 115.321 was the MOU with the Family Crisis Center, which indicates victim advocacy services would be provided if needed. The facility's coordinated response plan indicates one of the responsibilities of the Compliance Manager/Investigator is to refer residents for a forensic examination by contacting the Madison Memorial Hospital. During her interview, the SAFE/SANE nurse said a SAFE/SANE nurse is always on call and always available to provide forensic examinations for St. Anthony residents. She said an advocate would be notified and would be present during the exam.

For Standard 115.321, the Compliance Coordinator noted in the Issues Log, "All juveniles involved in a PREA allegation/incident are offered follow-up medical & mental health services. A licensed clinician provides the mental health services. JCC-St. Anthony has not had to access the services of a victim advocate at the crisis center, but as per the MOU the Family Crisis Center has someone on call 24 hours a day. If a staff from St. Anthony were needed to provide these services, a licensed clinician the juvenile was familiar & comfortable with would be utilized."

During interviews, medical and mental health care staff members said that by policy, residents would receive unimpeded, immediate access to crisis intervention services, the level of which would be determined by the treatment team and the Compliance Manager. Residents who reported sexual abuse said although they did not require medical services, they were offered counseling.

(b): As noted in Standard 115.364, IDJC Policy 613 requires that upon suspicion of and/or becoming aware of a possible sexual abuse incident occurring in the facility, a staff member will ensure the safety of the alleged victim, take steps to separate the alleged offender, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence, and if the abuse occurred within a time frame that still allows for evidence collection, the staff member shall request that no actions are taken by the alleged victim or abuser that could destroy physical evidence.

The coordinated response plan expands the first responder duties and provides detailed instructions on actions to be taken including ensuring the safety of the victim, separating all parties involved, offer medical and mental health services, notify the duty officer and the PREA Compliance Manager, protecting the scene, preserving physical evidence, complete required documentation, ensure confidentiality of the investigation, and follow directives from law enforcement, the Compliance Manager, and the Superintendent or designee. During interviews, staff members communicated their understanding of first responder duties.

Corrective actions and responses to incidents of alleged sexual abuse or harassment are documented in each incident review. As noted in Standard 115.352, initial reviews and corrective actions must be completed within 48 hours. As required by this provision, an action consistently documented is a referral to counseling.

(b): IDJC policy outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused. The PAQ indicates there were zero instances where a non-security staff member was the first responder to an allegation of sexual abuse and; therefore, circumstances in which a non-security staff member needed to request that residents not take actions that would destroy physical evidence. In a follow-up question in the issues log, the facility reported that all staff members are considered first responders. During interviews with random staff members, they could articulate their first responder duties, which would include separating the alleged victim and alleged abuser, protecting the scene and any physical evidence, reporting the incident to supervisors, and documenting the incident.

Staff first responders must take preliminary steps to protect the victim pursuant to standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Interviews with staff demonstrated their knowledge of first responder protocols and procedures for cases of sexual abuse. The coordinated response plan includes the notification of medical and mental health care staff as a first responder duty.

(c): IDJC policy and the St. Anthony Coordinated Response Plan state that juvenile victims of sexual abuse are offered and provided testing, treatment, and follow up care for sexually transmitted infections free of charge as medically indicated. During interviews, the medical staff member said the services pursuant to this provision would be provided immediately. The residents who reported sexual abuse said they were given information about preventing sexual transmitted infections after they made their reports.

(d): As noted in provision (c), treatment services are provided free of charge.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) resident victims of sexual abuse shall receive access to emergency medical treatment and crisis interventions as determined by medical and mental health practitioners; b) if no qualified staff members are on duty at the time of report of recent abuse, the first responder shall take steps pursuant to standard 115.362 to protect the resident; c) resident victims of sexual abuse while incarcerated shall be offered information and access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted Standards of care; and d) treatment shall be provided at no cost to the resident.

The auditor determined that IDJC policy addresses each element of this standard, which demonstrates compliance with provisions (a) – (d). The coordinated response plan contains information about the emergency medical treatment for victims of sexual abuse, which provides additional evidence of compliance with provision (a). Resident files provided evidence that medical and mental health care services are consistently provided to all residents and provided at no charge, which supports compliance with provisions (c) and (d). Additional evidence supporting compliance with provisions (b), (c), and (d) was based on interview responses. Staff members articulated their knowledge of the general medical and mental health care services all youth receive and emergency services that would be provided if needed. Residents also confirmed that they receive general medical and mental health care services at no cost.

Corrective Action: None

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

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

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be*

residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) Yes No NA

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 404 – Observation and Assessment Evaluations
3. IDJC Policy 640 – Observation and Intake
4. IDJC Policy 835 – Sexual Abuse
5. St. Anthony Coordinated Response Plan
6. Staffing notes for a resident who disclosed prior sexual abuser
7. Screen shot to evidence the resident's counseling sessions

Interviews:

1. Medical and mental health care staff
2. Staff who conduct risk assessments

Observations:

1. Facility clinic and the Assessment Center

(a): IDJC offers medical and mental health evaluations and appropriate treatment to all youth who are victims of sexual abuse in any facility. IDJC Policy 404 requires that a “clinician conduct a clinical interview including a mental status examination.” The policy also states, “Every juvenile admitted to O&A is administered a Risk of Sexual Victimization/Perpetration Screener (DJC-269) by a Clinician within three calendar days of the juvenile’s entry into O&A.” IDJC Policy 640 requires that “juveniles are promptly screened to identify risk to self or others, to assess for immediate medical and mental health needs, and are given basic information, including a description of their rights and responsibilities while in IDJC custody.”

Interviews with medical and mental health staff indicated all residents undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed.

As noted above in Standard 115.381 provision (a), the facility uploaded documentation showing a resident’s disclosure of sexual victimization, the subsequent staffing notes, and approval for the referral for clinical services. A screen shot was uploaded that indicated the resident received multiple individual counseling sessions as result of the disclosure. While on site, the auditor reviewed additional records to ensure documentation of initial and on-going medical and mental health care services were provided to residents.

(b): IDJC Policy 835 require that “juvenile victims of sexual abuse while incarcerated are offered and provided testing, treatment, and follow up care.” The policy also stipulates that medical and mental health records become “part of that juvenile’s electronic medical record. Any and all disclosures are made in accordance with state and federal law, including HIPAA (Health Insurance Portability and Accountability Act).” This policy ensures the care would continue if the resident transferred to another facility. Medical and mental health care staff members said counseling and therapy is offered to all residents, including offenders and victims. As noted in provision (a), the auditor reviewed additional records to ensure documentation of initial and on-going medical and mental health care services were provided to residents.

(c): During interviews, medical and mental health care staff reported the level of care received at St. Anthony meets with or exceeds the community level of care.

(d): IDJC Policy 835 states that juvenile victims of sexual abuse are offered and provided testing, treatment as medically indicated. The female youth interviewed who reported sexual abuse said this service was not needed and thus, not provided.

(e): IDJC Policy 835 states that “if pregnancy results from sexual abuse while incarcerated, the juvenile receives timely and comprehensive information about and access to all pregnancy-related medical services and treatment consistent with state law and the regulations of the jurisdiction.” The female

youth interviewed who reported sexual abuse said this service was not needed and thus, not provided. The medical staff member said this service would be provided if necessary.

(f): IDJC policy states “juvenile victims of sexual abuse while incarcerated are offered and provided testing, treatment, and follow up care for sexually transmitted infections free of charge as medically indicated.” The Compliance Manager and Nurse Manager provided information during the post on-site audit phase that the facility had provided free STD testing on two occasions following PREA incidents that had occurred between the previous audit in 2016 and the current audit period.

(g): IDJC policy requires that all treatment services are provided to the victim without financial cost. This was verified in an email from the Nurse Manager following the on-site audit.

(h): IDJC Policy 404 indicates residents who are committed to the facility 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.” This policy also states, residents who are recommitted 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.” Residents with substantiated documentation of sexual misconduct “receive an in-depth, sexual offender-specific, individual assessment” and treatment plan based on the resident’s risk to offend sexually. Medical and mental health staff members reported that all youth receive a mental health evaluation during intake and periodically throughout their stay.

Summary of Findings:

The auditor compared IDJC policy to the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall offer medical and mental health evaluations to all residents who have been victimized in a juvenile facility; b) the evaluation and treatment shall include follow-up services, treatment plans, and referrals for continued care if necessary; c) the facility shall provide services consistent with the community level of care; d) resident victims of vaginal penetration shall be offered pregnancy tests; e) if pregnancy results, the victim shall receive access to lawful pregnancy-related medical services; f) resident victims while incarcerated shall be offered tests for sexually transmitted infections; g) treatment shall be provided at no cost to the resident; and h) the facility shall attempt to evaluate all known resident-on-resident abusers within 60 days of learning of such history and offer treatment when deemed appropriate by mental health care staff.

The auditor determined that IDJC policy addresses all elements, which supports compliance with provisions (a) – (h). During interviews, residents said they receive medical and mental health care services, which provided additional support of compliance with these provisions. Compliance with provision (g) was based on interviews, during which staff and residents confirmed medical and mental health care services are provided at no cost. St. Anthony provides ongoing treatment to all residents and provides specific treatment to residents engaging in sexual misconduct, which supported compliance with provision (h). Since the facility demonstrated compliance with all provisions, the auditor determined St. Anthony meets the requirements of this standard.

Corrective Action: None

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

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

115.386 (e)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. PREA Incident Review Reports
4. Annual IDCJ PREA Report 2019

Interviews:

1. Superintendent
2. PREA Compliance Manager
3. Incident review team members

Observations: Observations of changes, modifications, and improvements resulting from incident reviews were noted during the facility inspection.

(a): IDJC policy requires the facility to conduct an incident review following an allegation of sexual abuse or harassment. Policy states the PREA Coordinator is responsible for tracking sexual abuse investigation activities, reviewing incident responses, and maintaining records related to sexual abuse incidents and responses.

As the PAQ indicates, in the past 12 months, there have been four investigations of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding unfounded incidents.

During the pre-audit phase, the PREA Incident Review reports were provided for each of the four facility investigations, which included three that were substantiated and one unsubstantiated. Additionally, the

facility provided one incident review with a determination of unfounded and six reviews with determinations of non-abusive contact. On all incident review forms, the team members included the facility Superintendent, PREA Compliance Coordinator, PREA Compliance Manager, and the Deputy Attorney General.

(b): IDJC policy requires that reviews occur within 30 days of the conclusion of the investigation. In the past 12 months, the investigations conducted pursuant to this provision were completed within 30 days, which was evidenced by the incident review reports. Each report contained the date of the incident or disclosure and the date the review was completed.

(c): Based on a review of the incident review reports, the review team includes the facility Superintendent, the Compliance Manager, the Compliance Coordinator, and Deputy Attorney General. The incident review reports indicate information from other facility staff members is gathered and documented in the review report. The Superintendent stated that the review team includes the staff members pursuant to this provision.

(d): Section B of the incident review reports includes each of the five elements to be considered pursuant to this provision including determining 1) whether policy needs to be changed, 2) whether the incident was motivated by specific factors such as race, 3) whether there were physical barriers enabling the incident to occur, 4) whether there was adequate staffing, and 5) whether monitoring technology should be augmented. The sixth element in this provision required the facility to prepare a report of the findings that includes the determination and corrective actions.

The Superintendent, Compliance Manager, and a member of the incident review team demonstrated their knowledge of the items that would be considered and provided examples of resulting actions taken in response to the review team's findings such as allowing a resident to shower first or last, relocating furniture, adding security mirrors, adding video monitoring to staff desk areas. During the facility inspection, the auditor's attention was called to several examples of these improvements and/or changes.

(e): IDJC policy requires that the facility PREA Compliance Manager monitor the implementation of the corrective actions the review team recommends. Corrective actions and responses to the review team's findings included providing medical and mental health care, changing the shower routine, revising transportation practices, placing residents on safety plans, notifying law enforcement, informing relevant staff members, moving a resident's bed to be closer to staff members, and monitoring for retaliation.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall conduct an incident review at the conclusion of every sexual abuse investigation; b) the review shall be conducted within 30 days of the conclusion; c) the review team shall include upper-level management and input from line supervisors, investigators, and medical and mental health care staff; d) the review team shall consider policy or practice change, potential motivations of the incident, the area where the incidence allegedly occurred, and monitoring technology, and prepare a report of findings; and e) the facility shall implement recommendations for improvement or document the reasons for not doing so.

Based on review of IDJC policy, review of incident review reports, observations of actions taken as a result of incident reviews, and interviews with the Superintendent, PREA Compliance Manager, and a staff member on the incident review team, the auditor finds the facility in compliance with this standard.

Corrective Action: None

Standard 115.387: Data collection

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

115.387 (a)

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

115.387 (b)

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

115.387 (c)

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

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

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

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC Policy 613 – PREA Compliance
3. IDJC PREA Incident Review form
4. 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report

Interviews: No interviews were required relative to this standard. In our past reports, we included interview info here but it's not required per the audit tool.

Observations: No observations relative to this standard are required.

(a): IDJC policy requires that the IDJC establishes a data collection systems to track sexual abuse. Policy also states that the Compliance Coordinator is responsible for establishing sexual abuse incident data collection systems, tracking this data, compiling the data, reviewing incident responses, maintaining records of the responses, conducting reviews, and completing the annual Survey of Sexual Violence issued by the DOJ. Additionally, the facility Compliance serves as the liaison between the Compliance Coordinator and the facility and is responsible for compiling, tracking, and forwarding PREA-related incidents to the Coordinator.

The IDJC PREA Incident Review form contains a page titled Section C: Survey of Sexual Victimization: Alleged Conduct, which includes the five DOJ standardized categories and corresponding definitions of sexual conduct. All PREA-related incidents are documented on this form, and multiple completed forms were provided for review. Additionally, all reported allegations of sexual abuse for the previous 12 months was included on a form and uploaded prior to the on-site audit. The agency develops its data collection instrument to include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U.S. Department of Justice (DOJ).

(b): IDJC policy requires the PREA Compliance Coordinator to complete the Survey of Sexual Violence annually. The auditor reviewed the 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report, which contained the five DOJ categories and definitions of types of sexual conduct, aggregated data comparing 2017 and 2018 statistics, findings, and actions taken.

(d): IDJC policy requires that the facility and agency maintain, review, and collect data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident

reviews. The auditor reviewed incident forms, locally data collected, and aggregated agency data contained in the Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report.

(e): IDJC policy requires that the “director will be notified of sexual abuse incidents occurring within the facilities or at a contract provider that involve staff, force/threats of force, or penetration. For all other incidents, the director will be notified at the discretion of the Superintendent or PREA coordinator.” The 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report contains data collected from contracted providers.

(f): The 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report indicates the agency provided the DOJ with data from the previous two years.

Summary of Findings:

The auditor assessed IDJC policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall review and assess the data collected pursuant to Standard 115.387 and prepare a report of findings; b) the report shall include a comparison of the current year’s data and corrective actions to prior years and provide the agency’s progress in addressing sexual abuse; c) the report shall be approved by the agency head and be made available to the public; and d) the agency may redact material if it presents a clear and specific threat to the safety and security of the facility.

The auditor determined IDJC policy addresses provisions (a) – (e). Additional compliance with these provisions and provision (f) was based on the annual report containing aggregated data from the agency and contract providers. Since the facility demonstrated compliance with each provision, the auditor determined that St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.388: Data review for corrective action

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

115.388 (a)

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

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC website

Interviews:

1. Agency Head
2. PREA Coordinator
3. PREA Compliance Manager

Observations: No observations relative to this standard were required.

(a): The PAQ indicates IDJC reviews aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. The 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report contains the collected data, a summary of findings, information regarding PREA audits conducted at IDJC facilities, and actions taken based on the data. The Agency Head indicated his knowledge of the data review and said that actions taken based on the data have included the justification to install cameras in transport vehicles. The Compliance Coordinator said the annual report is generated based on incidents from each facility, includes corrective actions taken by each facility and the agency, and is used to improve training and practices. He stated all cases are stored in a secure, password-protected file and the retention schedule follows the PREA standard requirements. The Compliance Manager said an annual report is generated and submitted to the Compliance Coordinator.

(b): The 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report contains the collected data, a summary of findings, information regarding PREA audits conducted at IDJC facilities, and actions taken based on the data.

(c): The IDJC website contains information regarding corrective actions taken based on data, information about the agency's participation in the DOJ Survey of Sexual Violence since 2004, and a statement about how the data is used including identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions. The website includes links to the annual PREA report, facility-specific sexual abuse data, and facility PREA audit reports.

(d): A review of the posted data indicates IDJC takes appropriate measures to protect specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. The Compliance Coordinator reported that since no identifying information is included in the report, no redactions are needed.

Summary of Findings:

The auditor reviewed the 2019 Annual Idaho Department of Juvenile Corrections Prison Rape Elimination Act Report, the IDJC website, and interview notes and compared these items with the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall review and assess the data collected pursuant to Standard 115.387 and prepare a report of findings; b) the report shall include a comparison of the current year's data and corrective actions to prior years and provide the agency's progress in addressing sexual abuse; c) the report shall be approved by the agency head and be made available to the public; and d) the agency may redact material if it presents a clear and specific threat to the safety and security of the facility.

The auditor determined the annual report provided sufficient evidence of compliance with provisions (a) and (b). Additional compliance with provision (a) was based on interviews with the Agency Head, Compliance Coordinator, and Compliance Manager, as they all demonstrated their knowledge and understanding of collecting data for the report and using the data to inform decisions. The auditor based compliance with provision (c) on a review of the agency website, which contains more than the required information. During interviews, the Compliance Coordinator stated that no personal information is included in the report, which was confirmed during the auditor's review of the reports, which supports compliance with provision (d). Since the facility demonstrated compliance with each provision, the auditor determined that St. Anthony meets the requirements of this standard.

Corrective Action: None

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

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

115.389 (b)

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

115.389 (c)

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

115.389 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ

2. IDJC Policy 613 – PREA Compliance
3. Quality Improvement Services Bureau Handbook (QIS Handbook)
4. IDJC website
5. The 2019 Annual IDJC PREA Report

Interviews:

1. Superintendent
2. Compliance Coordinator

Observations: No observations relative to this standard were required.

(a): The QIS Handbook requires that all sexual abuse data is securely retained. The Compliance Coordinator confirmed compliance and stated the data is password protected.

(b): Agency policy does not require that IDJC post on its website all aggregated sexual abuse data. However, the data is included in the annual PREA report, which was posted on the public website.

(c): A review of the published data revealed that agency removes all personal identifiers prior to making aggregated sexual abuse data publicly available.

(d): The QIS Handbook indicates the Agency PREA Coordinator shall retain, in a secure location, all reports related to PREA allegations as long as the alleged abuser is incarcerated or employed by the agency, plus ten years, unless the abuse was committed by a juvenile and applicable law requires a shorter period of retention.

Summary of Findings:

The auditor assessed agency policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall ensure the data collected pursuant to Standard 115.387 are securely retained; b) the agency shall make the data available to the public; c) the agency removes personal identifiers from the public data; and d) the agency maintains the data for 10 years. The auditor determined the QIS Handbook addresses provisions (b) and (c). The auditor visited the agency website to confirm the aggregated data with personal identifiers removed is readily available to the public. Compliance with provision (a) was based on the interview with the Compliance Coordinator who confirmed the data is securely stored in secure, password-protected files. Agency is required to maintain sexual abuse data for at least 10 years, which demonstrates compliance with provision (d). Since St. Anthony demonstrated compliance with all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. IDJC website
3. Photographs of audit notice posting
4. Overall documentation uploaded to a secure drive

Interviews: No interviews specific to this standard were conducted

Observations:

1. All areas within the facility

(a): IDJC policy requires that IDCJ facilities conduct audits pursuant to the Department of Justice requirement of every three years.

(b): The current audit was conducted in the third three-year audit cycle. During the previous audit cycle, PREA audits were conducted for three state-operated facilities and several private contract-care facilities.

(h): During the on-site portion of the audit, the auditor conducted a facility inspection and observed all areas inside and outside of the facility.

(i): The auditor received documentation relevant to each PREA standard prior to the on-site audit. Additional documents were requested and sent via email or uploaded to the secure drive. During the on-site portion of the audit numerous records were requested and reviewed including resident screening information, staff training records, background check information, and investigation reports to name a few.

(m): During the facility inspection, the auditor informally interviewed residents and staff throughout the campus. All formal youth interviews were conducted in the conference room in the Sawtooth/Assessment Center, which was a private setting.

(n): Prior to the on-site audit, notices were posted that included necessary contact information, thus enabling residents or staff members to send confidential information or correspondence to the auditor. The auditor did not receive such correspondence.

Summary of Findings:

The auditor assessed IDJC policy and practice against the elements of this standard, which require that: a) during the three-year period starting on August 21, 2013, and each three-year period thereafter, the agency shall ensure each facility is audited at least once; b) during each one-year period, the agency shall ensure that each facility type is audited; h) the auditor shall have access to and observe all areas of the facility; i) the auditor shall be permitted to request and receive relevant documents; m) the auditor shall be permitted to conduct private interviews with residents; and n) residents shall be permitted to send confidential correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Compliance with provision (a) was based on the auditor’s review of the links to PREA audit final reports that were conducted beginning in 2013, which evidenced that each facility was audited at least once during the three-year cycle. The auditor relied upon policy and the PREA-related activities included in the annual report to determine compliance with provision (b). Since the auditor team was provided access to all areas within the facility during the facility inspection, compliance with provision (h) was demonstrated. Since the auditor was granted access to and permitted to request and received relevant documents prior to, during, and after the on-site audit portions, compliance with provision (i) was demonstrated. The auditor was provided private areas in which to conduct interviews with residents, and thus demonstrated compliance with provision (m). The audit notices that were posted throughout the facility prior to the onsite audit enabled residents and staff to correspond with the auditor by including the auditor’s contact information; thus compliance with provision (n) was demonstrated. Since the facility complied with each provision, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. IDJC website: <http://www.idjc.idaho.gov/prea>
2. Final PREA audit reports posted on the IDJC website

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(f): The IDJC website contains prior final audit reports from the last three years and were posted within 90 days of issuance by the auditor.

Summary of Findings:

The auditor assessed IDJC practices against the elements of this standard, which require that: f) the agency shall ensure that the auditor's report is published on the agency website or otherwise made readily available to the public.

The auditor determined compliance with this provision by visiting the agency website and confirming previous audit reports are posted; thus the facility meets the requirements of this standard.

Corrective Action: None

AUDITOR CERTIFICATION

I certify that:

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

Auditor Instructions:

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

Dwight Sadler
Auditor Signature

June 30, 2020
Date

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

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