PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Auditor Information			
Auditor name: Walter J. Krauss, Psy. D.			
Address: 66 Elaine Drive Southbury, CT. 06488			
Email: waltjk@aol.com			
Telephone number: 860-707-4622			
Date of facility visit: May 13th and 14th, 2015			
Facility Information			
Facility name: Audubon Youth Development Center			
Facility physical address: 8711 LaGrange Road, Building D Louisville, Kentucky 40242			
Facility mailing address: (if different from above)			
Facility telephone number: 606-348-4201			
The facility is:	☐ Federal	**X** State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	**X** Other
Name of facility's Chief Executive Officer: John Ellington			
Number of staff assigned to the facility in the last 12 months: 50			
Designed facility capacity: 80			
Current population of facility: 20			
Facility security levels/inmate custody levels: Level III, IV, and Acute Unit			
Age range of the population: 12-21			
Name of PREA Compliance Manager: Diane Hiser		**Title:**	**Administrative Specialist III**
Email address: DianeR.Hiser@ky.gov		**Telephone number:**	**502-429-7287**
Agency Information			
Name of agency: Kentucky Department of Juvenile Justice			
Governing authority or parent agency: Kentucky Justice and Public Safety Cabinet			
Physical address: 1025 Capital Center Drive, 3rd Floor, Frankfort, Kentucky 40601-8205			
Mailing address: (if different from above)			
Telephone number: 502-573-2738			
Agency Chief Executive Officer			

Name: Bob Hater	**Title:**	**Commissioner**
Email address: BobD.Hater@ky.gov	**Telephone number:**	**502-573-2738**
Agency-Wide PREA Coordinator		
Name: LaShana Harris	**Title:**	**Assistant Director of Administrative Services**
Email address: LaShanaM.Harris@ky.gov	**Telephone number:**	**502-573-2738**

AUDIT FINDINGS

NARRATIVE:

Audubon Youth Development Center (YDC) is a male residential facility that has the capacity to house 80 residents (Custody Level III and IV) between the ages of 12 and 21. The facility is located in Louisville, Kentucky, and is operated by the Kentucky Department of Juvenile Justice. Audubon YDC houses teens that have been committed through the court system to the Department of Juvenile Justice. It is a unique facility in that, unlike other YDC's in Kentucky, it houses residents with four specific classifications: Intensive After Care Program (IAC), Severely Emotionally Disturbed (SED), Level IV, and Advanced Care Unit (ACU).

According to the Program Description, there is one dorm dedicated to those residents classified to the Intensive After Care Program. Identified as being at high risk to reoffend, these residents are introduced to a multi-faceted treatment approach that relies on the community and residential staff's coordination of services to meet each youth's individual needs in an effort to help facilitate a smooth transition back into their respective homes and the community. It is a 5.5 month program with those residents who are returning to their homes going on week long furloughs in the last two months to help with the transition. Those residents who do not go home are either stepped down to a group home or private child care.

The program for residents classified as Level-IV is for committed youth who are in need of a higher level of care and meet criteria for placement. They would be assigned to one 10 bed dorm. Two other dorms are dedicated to those classified as Severely Emotionally Disturbed. These individuals have either been previously housed in institutions for mental health or behavioral problems and/or are prescribed psychotropic medication. The four phase program takes place over a 5.5 month period and is centered on helping youth work through their emotional problems.

The Advanced Care Unit houses residents that have been determined through a selective ACU screening process to have a temporary mental health crisis or are in need of a mental health evaluation to help determine the most appropriate placement. Residents on this unit generally have more severe or acute behavioral problems and typically stay 60 days or less until their behavior has stabilized at which time they would return to their previous facility. This unit allows staff to help the residents work through any crises without requiring hospitalization and any cost that may incur.

Overall, the treatment program at Audubon YDC is designed to help youth learn productive behaviors that help them make a successful transition to the community. The program includes individual counseling, group counseling, family counseling, treatment team participation, progression through a phase system, academic and vocational programs, structured work experience, and personal health and hygiene maintenance. Cognitive therapy and behavior management are integral parts of the program. Individual counseling is provided a minimum of one hour per week and focuses on helping youth identify patterns of behavior, learning and practicing new ways to act, and monitoring progress. Each youth is assigned a youth counselor who also serves as the youth's facility case coordinator.

Through the educational program, all students have an Individual Plan of Instruction (IPI) and Individual Treatment Plan (ITP). Those required to have special education have an Individual Education Plan (IEP). Students are taught classes in Life Skills, English, Mathematics, Social Studies, and Science. Vocational programs include Building Maintenance, Masonry, Workplace Principles classes which are taught on site by teachers certified through the Department of Workforce Development.

Residents typically average 6-12 month stays at the facility. Residents at the YDC are allowed access to phones to contact attorneys and family members, are allowed at least one hour a day for exercise, and have access to books, bathroom and shower facilities. Audubon YDC was first accredited by the American Correctional Association in 2010 and successfully achieved re-accreditation status in 2013.

With the resignation of the designated PREA Compliance Manager on May 8, 2015, the facility currently employs 49 full time staff, and contracts with the Jefferson County Public School system for teachers. There are two contracted vocational staff as well. Security staff are referred to as Youth Workers or Youth Worker Supervisors. The nursing staff are State of Kentucky employees. There are no SANE or SAFE staff employed at the facility; however, those services would be provided at the Norton Kosair Children's Hospital in Louisville, Kentucky. The Kentucky Association of Sexual Assault Programs is contracted to provide rape crisis support and would meet any youth at the hospital to accompany them through the process, if the resident preferred.

The on-site PREA audit was conducted by Walter J. Krauss, Psy. D., DOJ Certified PREA Auditor, and the review of policies, procedures and most documentation as well as the written report completed by Peter Plant, DOJ Certified PREA Auditor in collaboration with W. J. Krauss. During the Pre-Audit phase the auditors reviewed a variety of documents provided by the agency and facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with PREA Standards. W.J. Krauss contacted Ms. LaShana Harris, prior to the site visits to discuss the agenda for each facility and to provide information on how best to facilitate the on-site auditing process.

The on-site audit was conducted on May 13 and May 14, 2015. An entrance meeting was held with the facility leadership, including John Ellington, Juvenile Facility Superintendent II; Diane Hiser, Administrative Specialist III / Acting PREA Compliance Manager; Kelly Dunn, Youth Worker Supervisor, and Auditor W.J. Krauss. Staff had previously received an agenda of the proceedings for the two day visit and the overall auditing process. Schedules with lists of staff, a schedule, and a list of the current residents within the facility was provided.

Subsequent to the introductory meeting, a comprehensive tour of the facility was led by Superintendent Ellington and Ms. Hiser. All areas of the facility were viewed, including each of the eight housing units, an administration area, a cafeteria with kitchen, education department, and medical unit, outside recreation area, and gymnasium. There are two vocational buildings, one for masonry and building maintenance classes, a restroom, and staff office. The second building is used for lawn equipment storage, which is not accessible to youth. There is no control room in the facility, but there are 121 cameras that record surveillance up to 30 days using a DVR system. As explained by Superintendent Ellington, surveillance cameras are not typically observed in real time by staff; however, the recorded information is used as a supervisory monitoring tool reviewed randomly and/or in response to any incidents that may occur. Supervisory staff have access to the camera monitoring system, including the Superintendent(s), Shift Supervisors, and the Treatment Coordinator. None of the cameras provide surveillance in the shower and toilet areas or areas where youth change clothing, with the exception of the isolation rooms. Per the Acting PREA Compliance Manager, if the female staff who have access to the surveillance footage witness nudity or sexual behavior they immediately close down the screen and contact the Superintendent or a male supervisor and it is documented immediately in the electronic file and the shift book. Despite excellent camera coverage throughout the facility, blind spots were identified during the tour, which will be described in the following section. PREA-related informational posters in English and Spanish and the PREA audit notice were observed posted throughout the facility.

During the on-site visit, interviews were conducted via telephone with the Agency Head (Commissioner Hayter) and Statewide PREA Coordinator (LaShana Harris). On-site interviews also included the Juvenile Facility Superintendent II, Administrative Specialist III / Acting PREA Compliance Manager, human resources staff, medical staff, and intake and screening staff. The Superintendent was interviewed to address multiple roles including the Incident Review Team, upper level staff responsible for conducting unannounced rounds and also responsible for monitoring for retaliation. Additionally, ten Youth Workers / Youth Worker Supervisors (security staff) were randomly selected and interviewed. Ten juvenile residents were randomly selected and interviewed as well.

Youth receive information on PREA and their rights during the intake process and again when their risk assessment is completed. Whether residents are new admissions or transfers, they are all provided the same PREA education and staff sit down with youth and review the materials provided so that they understand it. Youth who have experienced trauma, abuse, or victimization are provided treatment services, as needed.

On the day of the audit there were 20 residents housed at the facility with the average length of stay between 6-12 months. No youth had reported prior sexual victimization during their risk screening. No youth identified themselves as being

lesbian, gay, bisexual, transgender, intersex, or questioning, and no staff identified youth as gender nonconforming during the intake process. There were no youth identified as hearing or visually impaired or who had limited English proficiency; however, there was one youth that was interviewed that was considered to be cognitively limited. He explained that staff reviewed the PREA material in terms he was able to comprehend.

There was one allegation of sexual abuse in the past 12 months for which an investigation was conducted by both the IIB and the Louisville Metro Police; however, it was determined to be unfounded. Superintendent Ellington reported that the incident was 'debriefed' with key staff and supporting documentation was provided to verify the process despite the fact it was not required. In accordance with PREA standards and agency policy, the Superintendent indicated a more formal debriefing team meeting would take place as required if a sexual abuse allegation is ever determined to be substantiated or unsubstantiated.

DESCRIPTION OF FACILITY CHARACTERISTICS:

Audubon Youth Development Center is located on the Kentucky Children's Home Campus at 8711 LaGrange Road, Building D, in Louisville, Kentucky. The campus is situated in a picturesque and inviting setting. The main entrance leads to a lobby area where visitors sign in. To the left is a room that serves as a multipurpose visitation area/conference room and to the right administration offices and a break room. There were no PREA signs in the main lobby or visiting area, which Superintendent Ellington indicated would be addressed in both English and Spanish and since has been. In collaboration with the auditor, visitors and volunteers entering the facility will now receive a handout with PREA-related information, will sign in verifying that they have been informed that the facility has a zero tolerance policy for sexual abuse and sexual harassment, and provided with information on how to report such allegations. When you walk through two sets of locked doors, you enter the Rotunda area or the center of the facility, which divides the three areas into the West Wing, East Wing, and North Wing. There is no control room in the facility.

The residential area consists of an East Wing and a West Wing, both separated by the Rotunda Area. There are four housing units on each wing, with the West Wing having only single bunks in rooms and the East Wing having only double bunks. The West Wing consists of the four aforementioned housing units, including the Advanced Care Unit, two court yards, a conference room, kitchen and dining room area, staff offices, and a medical unit. There is no formal intake and processing area. Intakes are processed separately in the medical unit and the mental health offices.

The dining hall has two cameras for surveillance and the kitchen area has three. In the kitchen, a blind spot was observed in the storage area, but it was reported that juveniles are restricted from accessing that area. In order to access the medical unit, you pass through a set of doors, go through a small hallway with camera coverage and open a door to the left towards the middle of the hallway. If an individual kept walking instead of going in that door, you would find a small alcove to the left at the end of that hallway that presents a blind spot. In the medical unit, there are two cameras, but none in the rooms/offices. A Youth Worker of the same gender would accompany the residents in the examination rooms while another stays out in the main area of the medical unit. An English PREA sign was observed in the medical unit and a Spanish version was to be added later that day per Superintendent Ellington. There's an outdoor courtyard accessible to youth with two cameras. There's a small conference room where youth go to access the IIB hot line privately after signing a telephone log. According to staff and resident interviews, staff wait outside and observe through the window in the door to allow for privacy. Superintendent Ellington explained that typically when a resident requests to use the hot line, it happens immediately, unless there is a staffing issue. Overall, residents will have access to the IIB hot line within 24 hours. They also have the option of utilizing the Youth Counselor phones, but the Youth Counselors would need to sit in the room with them while they made the call. There are two grievance boxes, one on each wing, and another box located in the dining hall. Residents are provided forms and writing utensils to file grievances, if necessary. Each of the four West Wing units were inspected: West 500, West 600, West 700, and West 800.

West 600, West 700, and West 800 all have 10 single bunk rooms with two surveillance cameras on the unit. Each of the units has individual toilet and shower rooms that allow for privacy. West 700 and West 800 have isolation rooms with a combination toilet/sink in each. There is one camera in each of the isolation rooms allowing for surveillance. West 500 is the acute Advanced Care Unit, which is currently closed due to a decreased need for this level of care throughout the state. The unit is designed to be self-contained such that all programming would take place on the unit and the resident would not need to leave the unit. There are also 10 rooms on this unit with excellent camera coverage and a padded isolation room with a camera as well.

East Wing is not currently being used by Kentucky DJJ to house residents due to the low census; however, East 700 is currently being used by the Westport Group Home and East 500 is currently being used by DJJ for West Wing resident groups. There were no PREA signs posted on the East Wing units, but Superintendent Ellington reported that when they are used again, all signs and posters will be added to those units as well. In addition, signs have been added to the East 500 wing in English and Spanish at the request of the auditor.

The North Wing is where you will find the library, laundry, gymnasium, game room, staff offices, and a maintenance/mechanical room. The library has 2 well placed cameras, each of the classrooms has one, game room has one, and the large gymnasium has two surveillance cameras. The large walk-in gym closet does not have cameras inside, but the standard procedure is for residents to stand behind a line, the Youth Worker stands at the door, and one resident goes into the closet at a time. Superintendent Ellington indicated that all staff are aware of the policy to always be in camera view, particularly as it pertains to the gym closet, the Maintenance / Mechanical room, and the Janitor's closet on the West Wing. A blind spot was evident in the laundry room behind the washer machine. The superintendent indicated a convex mirror would be installed in the next few days to address the concern. Outside the North Wing are the two vocational buildings. Building #1, where the masonry and building maintenance classes are held include 1 camera in each of the two classrooms, 1 camera in the restroom hallway, and one camera in the staff office. Building #2 is used for lawn equipment storage and has two cameras; however, youth are not authorized to enter the building.

All West Wing units had professionally developed PREA posters in English and Spanish in addition to the posted Kentucky Association of Sexual Assault Programs rape crisis service phone numbers and addresses. It was recommended that the rape crisis information be posted lower on the wall, so as to make it easier for the juveniles to read. The PREA Audit notice was posted throughout the facility. In collaboration with the auditor, visitors and volunteers will now receive a handout with PREA-related information and will sign in verifying that they have been informed that the facility has a zero tolerance policy for sexual abuse and sexual harassment and provided with information on how to report such allegations. Posters containing both the hot line number to the Internal Investigations Branch (IIB), and the Kentucky Association of Sexual Assault Program rape crisis service address and phone number are prominently posted in all active housing units and the multipurpose area. On May 16, the Auditor called the IIB hotline, but was only able to leave a message. This auditor expressed concern to the PREA Coordinator that a hot line by definition has a person answering any such calls, but she explained that after hours or on weekends, an on-call staff member is immediately informed via a beeper type service and they are notified immediately to review and potentially address the concern immediately.

Number of standards exceeded: 5

Number of standards met: 28

Number of standards not met: 0

Number of standards not applicable: 8

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

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

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

The agency and facility have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. The policy details the approaches it uses to prevent, detect and respond to sexual abuse and sexual harassment. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy.

The agency has designated a Corporate Director as the Statewide PREA Coordinator. She is very knowledgeable of PREA requirements, devotes sufficient time and effort in assisting facility staff with PREA-related issues, and has the authority to implement corrective actions. The facility Administrative Specialist III currently serves as the interim PREA Compliance Manager after the previously assigned PREA Compliance Manager resigned five days before this audit. The interim PREA Compliance Manager and Superintendent were interviewed together as a result and both reported that she has sufficient time and authority to coordinate the facility's compliance with the PREA standards.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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

This standard is N/A.

Standard 115.313 Supervision and monitoring

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

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

The policy and completed staffing plan meet all the elements of the standard. The facility has initiated the practice of unannounced rounds, which was confirmed via documentation in the AYDC Weekly (Unannounced) Facility Tour Log by the Superintendent and Youth Services Program Supervisor. Staff and youth interviews and documentation confirmed the practice. The Superintendent also explained that he comes into the facility at all hours and because there's no control room, he cannot be seen by staff when he comes into the facility. He stated, "I go straight in my office 3rd shift and look at cameras", then proceeds to walk through the facility.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy states that staff will be trained in cross gender pat down searches. Nine of ten staff at the time of the on-site audit had been trained in cross gender, transgender, or intersex searches. The majority of staff requested additional training, which was provided to staff in collaboration with this auditor within the 30 day period following the on-site audit. Facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. This was confirmed during staff and youth interviews.

All toilets and showers are single capacity with doors and shower curtains. When the youth need to use the bathroom during daily schedule activities, there is a staff escort. Both review of policies and interviews with staff and youth confirmed that opposite gender staff are not permitted to enter or remain in the bathroom/shower areas of youth. None of the cameras field of view includes youth toilet/showers area, with the exception of the isolation rooms. Per the Acting PREA Compliance Manager, if the female staff who have access to the surveillance footage witness nudity or sexual behavior they immediately close down the screen and contact the Superintendent or a male supervisor and it is documented immediately in the electronic file and the shift book.

All staff and residents denied that opposite gender staff are announcing their presence when entering a housing unit as required. In collaboration with this auditor, staff were also trained within the 30 day period following the on-site audit on the agency policy to announce their presence when entering the unit and have implemented this procedure.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy prohibits the use of resident translators, resident readers, or other types of resident assistance. Youth interviews confirmed that youth are not asked, nor have been asked, to provide interpretive services. Based on the random staff interviews, staff were not aware of the availability of translation services. In collaboration with this auditor and prior to the end of the 30-day period following the on-site visit, staff were provided with recommended training on how to access support in working with the hearing or visually impaired as well as the interpretative phone service to help when the issue of non-English proficiency arises. If it is determined that youth have limited reading skills, intake staff will read the written materials to the youth.

During the audit there was one youth identified as having significant mental health concerns. When interviewed, the youth confirmed that the Youth Counselors met with him, discussed the PREA education materials in terms he could understand, and afterward was not in need of any additional assistance in understanding the material.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency conducts extensive background and reference checks with multiple entities, including the National Crime Information Center (NCIC) and Child Abuse and Neglect (CAN) registry. If during a background or registry check, any kind of record is found, the case is reviewed and ultimately signed off by the Commissioner before the hiring process proceeds or the employee is permitted to continue employment. There is a new policy and system to conduct background checks every 5 years has been established. The policy addresses all of the elements of this standard and all ten random personnel files reviewed met the standard criteria.

All ten staff had NCIC background and Child Abuse and Neglect (CAN) registry checks. This auditor contacted Central Office staff to review the ten selected staff checks to verify they had actually been cleared and when. Staff authorize the checks,

which in turn get sent to Central Office for processing with a copy staying in their personnel file at the facility. An email is later sent from Central Office indicating whether there was a 'Record Found' or 'No Record'. The auditor contacted Central Office staff to review the ten staff background checks selected to verify they had actually been cleared and when. All ten CAN checks had 'No Record' found. Six of ten staff cleared the NCIC checks with 'No Record' and an additional four had "Record Found". In those four cases, which were not considered PREA-related, they were cleared and signed off by the Commissioner.

Standard 115.318 Upgrades to facilities and technologies

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

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

The facility has not upgraded any facility buildings or facility technology in the last year. This is N/A.

Standard 115.321 Evidence protocol and forensic medical examinations

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

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

The facility does not conduct administrative or criminal investigations. The former are conducted by the Internal Investigation Branch (IIB), and the latter are conducted by the Louisville Metro Police Department.

Forensic medical exams, when needed, would be conducted at the Norton Kosair Children's Hospital, located in Louisville, Kentucky, at no cost to the resident or their family. The facility has an MOU with the Kentucky Association of Sexual Assault Programs (KASAP).

Standard 115.322 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy ensures that an administrative/criminal investigation is completed, as required. Policy and Kentucky state law requires that all allegations be reported to IIB for investigation. Allegations that are criminal in nature are reported to the Kentucky State Police.

There was one allegation of sexual abuse in the past 12 months for which an investigation was conducted by both the IIB and the Louisville Metro Police; however, it was determined to be unfounded.

Standard 115.331 Employee training

☒Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All current staff have completed both facility and Kentucky State PREA Training which includes all of the required topics. This training is specific to youth who are referred for treatment at this facility. Refresher training is provided every year. Staff also review and sign the Kentucky State Acknowledgement and Notification PREA form. Staff interviews and documentation confirmed the practice.

Upon the request of staff during the random staff interviews and in collaboration with this auditor, an additional training was provided by administration within the 30 day period following the on-site audit, to clarify the agency's investigative process.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy meets the requirements of the standard. The facility has both volunteers and contractors, and they complete the same PREA training that staff are required to complete. Staff interviews and documentation verified completion of the training

Standard 115.333 Resident education

☒Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Initial resident education is provided during the intake admission process by Youth Counselors, typically within 24 hours. Residents are provided the PREA pamphlet in both English and Spanish and the Youth Counselors sit with the residents and review the materials with the resident so that they are clear on the zero tolerance policy. They are also provided additional written material that describes their right to be safe from sexual violence and information on how the various ways they can report an allegation or receive services. If it is determined that youth have limited reading skills, intake staff will read the written materials to the youth.

This information is further reviewed in greater detail and supplemented in groups and individual counseling sessions soon after the youth arrives at the facility.

Posters displaying the phone numbers for PREA Hotline and the IIB are visible to youth and staff in the West Wing housing units, hallways, and main lobby area. In collaboration with this auditor, additional posters were posted in both English and Spanish in the multipurpose visitation area/conference room and the group room on the East Wing. At this auditor's recommendation, KASAP signs were moved to be more visible by youth and youth were informed of this additional resource during the 30 day period following the on-site visit. Youth interviews confirmed that youth understand the PREA education they receive and could articulate their rights and the various ways they can report an allegation.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. The facility does not conduct administrative or criminal investigations; however, staff will assist in providing the IIB and Kentucky State Police with information upon request.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Medical and Mental Health staff receive specialized Medical and Mental Health professionals training provided through the State of Kentucky. The facility does not conduct forensic medical exams. As fulltime staff, they also receive the same PREA training as other staff. Documentation verified both the initial and specialized trainings. Documentation was reviewed that verified completion of this training by selected medical and mental health staff.

Standard 115.341 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility utilizes the State of Kentucky Department of Juvenile Justice "Vulnerability Assessment Instrument: Sexual Assault Victim/Assailant Profile Checklist" to provide information on a resident's risk of "Vulnerability Victimization" as well as their risk of engaging in "Sexually Aggressive" and "Violent Aggressive" behavior. The instrument meets all PREA requirements in this regard. This screening is conducted for all youth who enter the facility within 72 hours, and most commonly, within 24 hours. This was evident in the ten random juvenile interviews and record review following those interviews. Nine of ten records reviewed had been screened within 24 hours of their arrival. The screening consists of both youth interview questions and staff review of collateral information. Youth are assessed quarterly, except if a youth makes an allegation of sexual abuse or harassment, the entire screening is re-conducted. Four of the ten records reviewed were not completed quarterly per agency

policy, but those cases were reportedly assigned to a Treatment Coordinator who had unfortunately passed away just three weeks prior to this audit. Even so, the facility's review process exceeded the standard requirement in this regard. Facility policy strictly controls the dissemination of information gathered from the screening on a "need to know" basis.

The assessment tool is currently in the process of being validated by the University of Kentucky. This auditor spoke with the PREA Coordinator to express concern that the item related to a resident's identification as gay, lesbian, bisexual, transgender, or intersex and staff perception of the youth as gender non-conforming did not receive a value in the assessment score, but she indicated that is being accounted for by the University of Kentucky's process.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The current housing, educational, and work assignment classification system is based on the screening, assessment, and collateral information gathered during the intake process to ensure each youth's safety and security.

The facility has two housing wings: East and West. Currently, only the West Wing, which has only single cells, is being utilized. The facility has the capacity to house 80 juveniles. Education and treatment services are provided on site.

There were no residents who had identified themselves as lesbian, gay, bisexual, transgender, questioning, or intersex during the audit. Facility policy prohibits housing and related assignments based solely on sexual orientation or identification nor are they isolated. This was confirmed through staff interviews. Each youth's safety is paramount in making these assignments, regardless of other issues.

Three juveniles were identified as being at risk for Vulnerable Victimization. The Superintendent indicated that once identified as being at risk for victimization, residents are housed in single cells, staff awareness is heightened, residents may be put on "No Contact" with particular staff or other residents, and/or a resident could be moved within the facility or system with the ultimate goal of keeping residents safe and secure. The options are similar for those who score as Violent Aggressive or Sexually Aggressive although the PREA Coordinator is working with the PREA Compliance Managers statewide to develop additional options as well.

The facility does not utilize isolation as a form of placement for LGBTQI youth.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Youth interviews confirmed that the facility provides multiple internal ways for residents to privately report sexual abuse and harassment and retaliation by residents or staff. All youth identified the reporting numbers for state agencies listed on the posters in the hallway, as being one means of reporting. They also stated that they can confide in their lawyer, their Juvenile Service Worker, tell a family member, or tell a staff member. Youth also confirmed that they have access to writing materials, both during the school day, as well as in the housing areas.

Staff interviews confirmed that staff accept all reports, whether verbal or written, and from any source. The interviews also confirmed that staff can privately report sexual abuse or harassment of residents, using the PREA and/or IIB hotline number. Although the Superintendent reported staff allow the residents access to the IIB hotline most often immediately, but always within 24 hours, three residents reported it has taken more than 24 hours to be escorted to the IIB phone during the random resident interviews.

Standard 115.352 Exhaustion of administrative remedies

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

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

Although there is a facility grievance procedure available for the youth, policy dictates that PREA allegations are not officially utilized by the youth in this capacity. This standard is N/A.

Standard 115.353 Resident access to outside confidential support services

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

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

The facility currently has an MOU with the KASAP agency to provide victim advocate and supportive services to youth upon request. Posters displaying the phone numbers for PREA Hotline and the IIB are visible to youth and staff in the West Wing housing units, hallways, and main lobby area. In collaboration with this auditor, additional posters were posted in both English and Spanish in the multipurpose visitation area/conference room and the group room on the East Wing. At this auditor's recommendation, KASAP signs were moved to be more visible by youth and youth were informed of this additional resource during the 30 day period following the on-site visit. Youth interviews confirmed that residents are aware of these posters and their right to call and make reports.

Staff and resident interviews confirmed that staff provide youth with the limitations of confidentiality, regarding mandatory reporting laws. Resident communications are not monitored. Youth interviews confirmed that those residents who currently have attorneys can communicate with them confidentially. None reported being denied access to their attorneys. All youth reported that they have family visitation and that they have never been denied access to their families. All youth are allowed to make phone calls each week to family members.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility uses the IIB and rape crisis support hotlines for this purpose. In collaboration with the auditor, visitors and volunteers entering the facility will now receive a handout with PREA-related information, will sign in verifying that they have been informed that the facility has a zero tolerance policy for sexual abuse and sexual harassment, and provided with information on how to report such allegations.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All staff are mandated child abuse reporters and receive appropriate training. Facility policy requires all staff to also report any retaliation against youth or staff who made a report.

Facility policy strictly prohibits the disclosure of information related to a report of sexual abuse, except on an "as needed" basis in order to make treatment and related decision.

Staff interviews confirmed that medical staff are mandated child abuse reporters and that they inform youth of their duty to report and the limitations of confidentiality.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Although there were no instances during the previous 12 months where a youth was subject to substantial risk of imminent sexual abuse, staff interviews confirmed that staff have received training as to how to immediately protect a youth by separating the youth and alleged perpetrator, confident in their roles as first responders, notifying their supervisor, and completing all necessary documentation, i.e. incident reports. It was clear that all staff were aware that their primary responsibility is the safety of youth in the facility.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

While there has not been an allegation of sexual abuse at a prior facility in the previous 12 months, facility policy requires prompt notification, documentation and follow-up with the prior facility. Also, Kentucky law requires mandated reporters to report such an allegation to IIB.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy includes the requirements of the standard. Staff interviews confirmed that staff have received first responder training and articulated with confidence the steps they are to take when responding to an incident of sexual abuse.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a detailed coordinated response plan that also includes a First Responder protocol and First Responder Check List that ensures the highest level of coordination amongst and between the various actors.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. There are no agreements of the type defined in the standard in place or contemplated.

Standard 115.367 Agency protection against retaliation

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

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

There is a policy that protects all youth and staff from retaliation. This policy includes protective measures, follow up, and periodic status checks, as required by the standard. Although there have been no incidents of retaliation in the past 12 months, the Superintendent confidently articulated the specifics of the standard and requirements of the policy.

Standard 115.368 Post-allegation protective custody

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

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

This is N/A. The facility does not utilize any form of segregated housing. Per the Superintendent, the goal is to separate, not isolate. If an isolation room was ever used, which it has not to date for this purpose, it would just be to ensure the resident was safe. It would only be where the youth slept and would not be separated during daily activities.

Standard 115.371 Criminal and administrative agency investigations

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

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

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

This standard is N/A. The facility would only gather information upon the request of those agencies that would conduct any administrative or criminal investigations.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

This standard is N/A. The facility would only gather information upon the request of those agencies that would conduct any administrative or criminal investigations.

Standard 115.373 Reporting to residents

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

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

Facility policy requires the Superintendent or designee to inform the resident, in writing, who made the allegation of the outcome, as required by the standard, unless the allegation is unfounded.

Standard 115.376 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action. Disciplinary actions include a variety of sanctions, including termination. The sanction for a substantiated finding of sexual abuse is presumed to be termination in that such criminal charges usually result in incarceration. In any event, the policy states that the type of disciplinary action taken in a specific case depends on a number of variables and should be commensurate to the nature and circumstances of the acts committed, among other considerations.

Agency policy requires all allegations of sexual abuse to be reported to the Louisville Metro Police Department, regardless of whether the staff resigns or is terminated. This was confirmed in the interview with the Superintendent.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy clearly states that any volunteer or intern who engages in the sexual abuse or sexual harassment of an individual in the custody of the State of Kentucky will be terminated. Furthermore, any contractor who engages in similar behavior will be subject to contract cancellation. The statewide PREA Coordinator stated during her interview that all substantiated findings would be reported to applicable licensing authorities.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Whenever the IIB substantiates an allegation of sexual abuse against a youth, that youth becomes classified as a sex offender and is legally charged accordingly. Thus, there would be no disciplinary sanctions imposed by the facility.

The State PREA Coordinator also clarified that the facility does not make any determination, regarding whether a particular activity constitutes sexual abuse. This determination is made by the IIB investigator, court system, and/or Law Enforcement.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy complies with all elements of the standard. There were no youth who reported prior sexual victimization upon intake.

Interviews with medical and mental health staff confirmed that services would be offered and provided, if the youth was amenable. Facility policy strictly controls the dissemination of information related to sexual victimization or abusiveness of youth on an as "need to know" basis. Youth interviews confirmed that youth are informed of the limits of mandatory child abuse reporting and confidentiality.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy requirements require access to unconditional, immediate emergency medical and mental health services at no cost to the youth or family, not only for resident victims of sexual abuse, but for all youth in the facility, whenever they need it. Although there were no resident victims of sexual abuse during the prior 12 months, facility policy requires that the resident

victim be provided with information regarding STD prophylaxis. Medical staff reported that this would also be provided at the hospital.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Although there were no resident victims of sexual abuse in this facility during the prior 12 months, facility policy requires any resident victim be provided with ongoing medical and mental health services that are needed.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per the Superintendent, and consistent with agency policy, the sexual abuse incident review team includes Superintendents, the Treatment Coordinator, PREA Compliance Manager, Counselors, and the Youth Worker. He explained that facility staff debrief any incident that could be interpreted as PREA-related even if abuse is not alleged, although a formal Sexual Abuse Incident Review Team has not been convened.

There was one allegation of sexual abuse in the past 12 months for which an investigation was conducted by both the IIB and the Louisville Metro Police; however, it was determined to be unfounded. The investigative process was clearly documented, but because it was unfounded, a formal meeting with the sexual abuse incident review team was not required. The Superintendent reported that the incident was 'debriefed' with key staff informally and supporting documentation was provided to verify the process. In accordance with PREA standards and agency policy, the Superintendent indicated a more formal debriefing team meeting would take place as required if a sexual abuse allegation is ever determined to be substantiated or unsubstantiated.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency collects, aggregates, and maintains the data, as required by the standard. The data instrument collects the data necessary to answer all questions from the USDOJ Survey of Sexual Violence.

Standard 115.388 Data review for corrective action

☒Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has conducted the 2014 review and is posted on the State of Kentucky Department of Juvenile Justice Website. This auditor was also provided with the reviews from 2011, 2012, and 2013.

Standard 115.389 Data storage, publication, and destruction

☒Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency meets the requirements of this standard. DJJ has a public website and that features all federal PREA reports, PREA brochures, and information regarding PREA.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Walter J. Krauss, Psy.D., USDOJ-Certified PREA Auditor — 6-12-15

Auditor Signature — Date