PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 6/24/17

Auditor Information			
Auditor name: G. Peter Zeegers			
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Email: pete.zeegers@us.g4s.com			
Telephone number: 863-441-2495			
Date of facility visit: 5/22/2017			
Facility Information			
Facility name: Bowling Green Group Home			
Facility physical address: 3210 Porter Pike Bowling Green, Kentucky 42103			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 270-746-7458			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other GROUP HOME
Name of facility's Chief Executive Officer: Superintendent Kendall Williams			
Number of staff assigned to the facility in the last 12 months: 13			
Designed facility capacity: 8			
Current population of facility: 7			
Facility security levels/inmate custody levels: Level 2			
Age range of the population: 15-20			
Name of PREA Compliance Manager: Michael Rector		**Title:** Social Service Clinician II	
Email address: MichaelA.Rector@ky.gov		**Telephone number:** 270-746-7458	
Agency Information			
Name of agency: Kentucky Department of Juvenile Justice			
Governing authority or parent agency: *(if applicable)* Justice and Public Safety Cabinet			
Physical address: 1025 Capital Center Drive 3rd Floor, Frankfort, Kentucky 40601			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 502-573-2044			
Agency Chief Executive Officer			
Name: Carey D. Cockerell		**Title:** Commissioner	
Email address: CareyD.Cockerell@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

The Bowling Green Group Home is an 8-bed staff secure treatment program and is operated by the State of Kentucky, in Bowling Green, Kentucky. The facility serves adolescent boys, ages 15-20, who have been adjudicated delinquent and attend school daily directed at the Warren County Board of Education. A staff attends the school with the youth to provide security. The facility employs 13 full-time staff.

This audit was conducted by certified PREA Auditor G. Peter Zeegers. During the Pre-Audit phase, the auditor reviewed a variety of documents provided by the agency and facility. These included: policies and procedures, facility plans, protocols, training records, curricula, and other related documentation from the group home to demonstrate compliance with PREA Standards. The auditor conducted a Pre-Audit conference call a week prior to the on-site audit to provide agency and facility officials with the current status of the audit process, as well as to expand upon and clarify documents that had been submitted. The auditor did not receive any correspondence or requests from staff or youth prior to the on-site audit.

An on-site PREA Audit was conducted on May 22nd, 2017. The entrance meeting was attended by Kendall Williams, Superintendent; Michael Rector, Social Service Clinician, who also serves as the Facility PREA Compliance Manager, and G. Pete Zeegers, PREA Auditor. The on-site audit work plan was discussed. Identified/selected youth, staff, and specialized staff for interviews and additional pre-audit information was obtained. The entrance meeting was followed by a tour of the facility led by Facility PREA Compliance Manager Rector. All areas were viewed, including the administration area, visitation area, kitchen and dining area, indoor and outdoor recreation/leisure areas, medical area, and the dorm area. PREA-related informational posters and the PREA audit notices were observed posted throughout the facility. Additionally, informational pamphlets about PREA and the Sexual Assault Crisis Services were observed in every area where staff and youth might congregate. These pamphlets and posters were printed in English and Spanish. There were also posters with address and phone number to the Kentucky Association of Sexual Assault Programs (KASAP) Victim Advocates. No SANE or SAFE staff are employed at the facility; however, these professionals are provided at the Medical Center of Bowling Green located in Bowling Green, Kentucky, where forensic examinations would be conducted at no cost to the youth and/or their family.

On the day of the on-site audit seven youth were housed at the facility. There were no PREA-related sexual abuse allegations made in the previous twelve months. Two youth reported, during the intake process, previous sexual abuse. One youth identified themselves as being gay, bisexual, trans-gender, inter-sex, questioning, or gender nonconforming during the intake process. This youth reported that he had not been treated any differently than the other youth. There were no youth identified as hearing or visually impaired, developmentally delayed, or who had limited English proficiency.

There is one housing area at this facility. All seven youth were interviewed. There are three shifts at the facility. From the shift rosters the auditor randomly selected 3 staff from the 7-3 shift, 2 staff from the 3-11 shift and 2 staff from the 11-7 shift for interviewing (total 7, all that were available).A total of 12 specialized interviews were conducted. Specialized interviews were conducted with the Agency Commissioner, Statewide PREA Coordinator, the Superintendent, PREA Compliance Manager, Upper Level Manager, Medical Staff, Mental Health Staff, Intake Staff, Risk Screening Staff, Incident Review Staff, Retaliation Staff, and Grievance Staff.

Youth receive information regarding PREA and their rights during the intake process. The PREA information is printed in English and Spanish. Additionally, after youth are admitted to the facility they are provided additional information about sexual abuse and harassment in both individual and group treatment. Youth who have experienced trauma, abuse, or victimization are provided treatment services, as identified in their treatment process.

The Bowling Green Group Home was first accredited by the American Correctional Association in 1988 and has successfully achieved re-accreditation status through 2018.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility is located at 3210 Porter Pike in Bowling Green, Kentucky. The tour of the facility was conducted by the Facility PREA Compliance Manager. The facility is clean, in good repair, and well maintained. The main building is spacious enough for the staff and youth, with open hallways and good lighting. Once entered through a front door, which is located on the side of the building, there is a visitor sign-in/living room area. The front door is adjacent to the living room which includes: offices, laundry room, meeting area, dorm area, recreation/library, and kitchen/dining room area. There are three bedrooms to house a maximum of eight youth, along with two separate bathrooms with doors. Each bathroom has a toilet, a shower with a curtain, and a sink. There are cameras in the bedrooms, though not trained on the bathroom/showers. The youth are instructed to change clothes in the bathrooms. Youth use the bathrooms one at a time. This procedure was verified through youth and staff interviews. The top floor houses the administrative area. Regional State of Kentucky RN, and mental health staff, visit the facility once a week, or as needed. There is no designated office for the nursing staff but they find a confidential private area to conduct their medical business.

The outdoor recreation area consists of a basketball court and a field. There are 14 cameras located on facility grounds.

The PREA Audit Notice was posted on the bulletin boards in various hallways, as well as copies of the PREA brochure written in both English and Spanish. This is the same brochure given to youth during the intake process. Posters containing both the PREA hot-line to the Internal Investigations Branch (IIB) and addresses and phone numbers to the Kentucky Association of Sexual Assault Programs (KASAP), Hope Harbor, are prominently posted in the main lobby area and hallways.

SUMMARY OF AUDIT FINDINGS

The on-site audit was conducted on May 22nd, 2017. The seven youth screening instruments were reviewed. All were completed within the 72 hour time frame. The youth education acknowledgment forms were completed on day of intake. All staff background screenings were completed, as well as staff PREA training records being timely and complete. Policies and procedures were verified by reviewing staff files and the staff interviews.

All Agency Policies that were submitted to this PREA Auditor via thumb drive were reviewed prior to arrival for the on-site audit. Additionally, during the on-site audit many of these documents and relevant information were again reviewed. Policies included but not limited to: DJJ Policies 100, 102, 104, 121, 132, 133, 134, 140, 142, 149, 208, 300, 301, 310, 316.A, 318, 318.1, 318.2, 319, 321, 323, 325, 328, 400.1, 402, 402A, 402.1, 404.1, 404.3, 404.4, 404.8, 405, 405.1, 405.3, 405.5, 408.1, 416.1, 502, 505, and 506. PREA Policies: 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, and 912. Additional documents were viewed such as: Kentucky DJJ and Bowling Green GH Leadership Organizational Charts, employee and youth handbooks, DJJ General Directive 12-01, DJJ General Directive 10-02, various statutes, internal and external facility audit reports, PREA audit guide, PREA audit notices, Bowling Green GH layouts, facility program specific coordinated response plan, PREA juvenile standards, statewide and internal PREA-related memos and emails, policy amendment emails, staffing plan, various postings, staffing breakdown and rosters, master schedules, camera listings and locations, various logbooks, Staff Training Acknowledgement Forms, various staff trainings, youth educational information, Agency Mission Statements, and MOU's and agreements.

The results of the audit indicate that the facility is in full compliance with PREA Standards. A final report is being issued. The facility staff were very helpful, very professional, and well versed in PREA activities at the facility level. The facility response to privacy concerns confirms the facility commitment ensuring to the safety of all youth. It was a pleasure to work with the Superintendent and his staff.

Number of standards exceeded: 3

Number of standards met: 30

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 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.

Policy 901 mandates zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. The policy details the systems used to prevent, detect, and respond to sexual abuse and sexual harassment. The definitions of prohibited behaviors are clearly defined, as well as the sanctions for those who violate the policy.

The agency has designated a Statewide PREA Coordinator. She is very knowledgeable of PREA requirements and devotes sufficient time and effort in assisting facility staff with PREA-related issues. She has the authority to implement corrective actions if violations occur. The facility Social Service Clinician serves as the PREA Compliance Manager and reports that he 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. The State of Kentucky does not contract with other agencies for the confinement of residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 910 meets all the elements of the standard. The staffing plan has been completed and was updated on 9/21/2016. The facility embraces the practice of unannounced rounds. Unannounced rounds are documented in logbooks, shift reports, and sign-in forms. Staff interviews and review of documentation confirmed this practice.

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.

Policy 912 states that staff will be trained in cross gender pat down searches and for use only in exigent circumstances. A review of the training files verify that the training was completed. Facility policy prohibits searching or physically examining a trans-gender or inter-sex youth for the sole purpose of determining the youth's genital status. This was confirmed during youth interviews.

Each shower room has a door for privacy. Staff members are posted in each living unit when showers and/or bathrooms are in use. Review of the policies and interviews with staff and youth confirmed that opposite gender staff are not permitted to enter or remain in the shower areas of youth. None of the cameras field of view includes youth showers area.

The facility uses the practice of opposite gender staff announcing their presence when entering into the living area. Staff interviews confirmed the practice. Youth interviews also verify that opposite gender staff announce their presence when entering the living area.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

DJJ Policies 301 and 907 prohibits the use of youth translators, youth readers, or other types of assistance. Youth interviews confirmed that youth are not asked, nor have been asked, to provide interpretive services. The facility uses Language Services for interpreter services. If it is determined that a youth has limited reading skills, intake and screening staff will read the written materials to the youth until they acknowledge that they understand. All staff during interviews verified their knowledge of this standard. They know that they do not ask for youth interpreters or readers. During interviews staff indicated that they are aware of the Language Services and Associates and how to access and document.

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)

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The agency conducts extensive background checks and reference checks with multiple entities at hire according to policy 902. Background checks are also completed for promotions within the facility and the agency. The Agency conducts background checks every 5 years. Random samples of background screenings from staff and volunteers as well as 5 year background screenings were reviewed and found in compliance. Policy addresses all of the elements of this standard. All personnel files reviewed met the standard criteria. Staff interviews validate the policy.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A as there have been no facilities and technology upgrades

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 criminal investigations according to policy 901. Administrative investigations are conducted by the Internal Investigation Branch (IIB) with the criminal investigations conducted by the Kentucky State Police. There were no sexual abuse or sexual harassment allegations in the last 12 months.

Forensic medical exams, when needed, would be conducted at the Medical Center of Bowling Green located in Bowling, Kentucky, at no cost to the youth or their family.

The facility possesses MOU's with the Kentucky Association of Sexual Assault Programs (KASAP). The local (KASAP) Sexual Assault and Victim Advocate Agency is the Hope Harbor Program.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 906 ensures that an administrative or criminal investigation is completed. Administrative investigations are reported to IIB for investigation. Allegations that are criminal in nature are reported to the Kentucky State Police.

There were no PREA-related allegations made in the previous 12 months. Staff interviews confirm their knowledge of their reporting duties.

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. A random sample of staff training records were reviewed and found in compliance. The PREA training is required every other year. This training is specific to youth who are referred for treatment at this facility. Staff also review and sign the Kentucky State Acknowledgment and Notification PREA form. Staff interviews confirmed this practice.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policies 901, 903, and 911 meet the requirements of the standard. The facility does utilize volunteers and they are required to complete facility mandatory PREA training. Training records for past volunteers were available and reviewed. There were no current volunteers available for interview.

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 youth education is provided during the intake admission process per policy 907. Youth are provided a PREA pamphlet in English and Spanish. They are also provided additional written material on their right to be safe from sexual violence and information and how to report abuse or to request services. If it is determined that a youth has limited reading skills, intake staff will read the written materials to the youth. The facility uses Language Services phone service to assist a Non-English speaking youth. The youth watch a PREA video during intake. All youth interviews confirmed that they understood the PREA education receive and articulated their rights and the various ways they can report an allegation. All relevant youth educational materials were reviewed.

This information is further reviewed in greater detail and supplemented with groups and individual counseling sessions within a few days of arrival.

Posters displaying the phone numbers for PREA hot-line and the IIB are visible to youth and staff in the hallways and main lobby area.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A. The facility does not conduct administrative or criminal investigations.

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)

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Medical and Mental Health staff receive specialized Medical and Mental Health professional training through the State of Kentucky. Specialized training records for Medical and Mental Health staff were reviewed. Bowling Green GH has an Agency Regional Mental Health Clinician and a Regional RN to meet the mental health and medical needs of the facility. The clinicians are available in person or via phone and/or whenever needed. The specialized training meets the PREA training requirements. Medical and mental health staff also receive the same PREA training as other staff. Training documentation, as well as interviews with Mental Health and Medical staff verified the training. The facility does not conduct forensic medical exams.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 905 addresses risk screening. All youth receive a screening at intake, quarterly, as new information is obtained, and if a youth alleges, or is alleged, to have been a perpetrator of sexual abuse. The facility utilizes the Admission and Placement Screening form, which contains the elements required by the standard. If the results from the Risk Assessment Tool indicates a probability for victimization or sexually aggressive behavior and/or violent behavior, the youth shall be assigned to an appropriate room close to staff posts. If the screening indicates that a youth has experienced prior victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility mental health and/or medical specialist. The follow-up shall be completed within 14 days. The Intake staff also completes a review of any other medical and mental health screenings that may have been conducted, as well as conversations with the youth during the admission process. Existing court records and case files are also reviewed, if available. Policy requires intake staff, as part of the risk screening process, to ask youth about any gender non-

conforming appearance, mannerisms, or identification as LGBTQI. Files showed that all screenings were conducted within 72 hours of intake. Youth interviews confirmed that they received a risk screening during the admission process. Interviews with specialized staff who perform the risk screenings confirmed the comprehensive nature of the screenings and how housing decisions are made. Facility policy strictly controls the dissemination of information gathered from the screening on a "need to know" basis. Staff interviews confirm that the procedure is followed. Youth interviews verify the procedure. All seven youths' screening forms were reviewed and found in compliance.

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)

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The facility has three bedrooms with the capability of housing eight youth. The current housing and work assignments classification system is based on the assessment results. Screening, assessment, and collateral information gathered during the intake process is used to place youth in a bed that best ensures each youth's safety and security according to policy 905. Treatment services are provided on site, if needed. The facility does not utilize isolation as a form of placement for LGBTQI youth. There was one gay, bisexual, trans-gender, questioning, or inter-sex youth in the program during the audit. The youth stated that he has not been treated any differently than the other youth. Facility policy prohibits housing and related assignments based solely on sexual orientation or identification. This was confirmed through staff interviews. Each youth's safety is paramount in making these assignments, regardless of other issues.

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)

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Policies 208, 906, and 907 meet the requirements of the standard. Youth interviews confirmed that the facility provides multiple, internal ways for youth to privately report sexual abuse or harassment and retaliation by youth or staff. The youth identified the reporting numbers for state agencies listed on the posters in the hallways, as being one way of reporting. The external reporting agency is Internal Investigations Branch (IIB) serving under the Justice and Public Safety Cabinet. Youth 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 during the school day, as well as in the dorm area. 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 hotline and/or IIB number. There were no PREA allegations made in the last 12 months.

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)

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Although there is a facility grievance procedure available for the youth, policy 906 dictates that PREA allegations are not officially utilized by the youth in this capacity. The Facility Superintendent verified that if a youth turns in a PREA allegation through the grievance procedure, it is immediately reported to the appropriate agencies. 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 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 currently has MOU's with the KASAP agency to provide a victim advocate and supportive services to youth upon request. The Hope Harbor Program is the local KASAP agency. Posters containing the KASAP hot-line number are prominently posted in the hallways and lobby area. Youth interviews confirmed that they are aware of these posters and their right to call and receive confidential support services.

Staff and youth interviews confirmed that staff provide youth with the limitations of confidentiality regarding mandatory reporting laws. Youth communications are not monitored. Youth interviews confirmed that youth who have attorneys can communicate with them confidentially. No youth reported being denied access to their attorneys. All youth reported family visitation and have not been denied access to their families. All youth make phone calls each week to family members and/or write letters.

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)

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The facility uses the IIB and PREA hot-line for third party reporting. Parents and guardians are informed of the hot-line and the procedures for making a report. There is reporting information on the agencies' website at djj.ky.gov. There were no PREA allegations made in the last 12 months.

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. The external reporting agency is Internal Investigations Branch (IIB) serving under the Justice and Public Safety Cabinet. Facility policy 906 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 related decisions. Staff interviews confirmed that they know that they are mandatory reporters. Staff interviews also confirmed that medical staff are mandated child abuse reporters. Medical and Mental Health staff indicated during interviews 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.

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 they have received training as to how to immediately protect a youth by separating the youth and alleged perpetrator, notifying their supervisor, and completing an incident report. All staff expressed their primary responsibility is the safety of youth in the facility. Policy 908 states that staff will respond accordingly.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There has not been an allegation of sexual abuse reported by another facility in the previous 12 months. Policy 906 requires prompt notification, documentation, and follow-up with the particular reporting facility and is to report such an allegation to IIB. The interview with the Superintendent verified the practice.

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.

Policy 908 includes all requirements of the standard. Staff interviews confirmed that they have received first responder training. During interviews, staff could articulate the steps when responding to an incident of sexual abuse. Staff all knew of the individualized facility's coordinated response plan and checklist, and its location in the facility.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 908 meets all requirements of the standard. The facility has an individualized coordinated response plan that includes a First Responder protocol and First Responder Check List that ensures the highest level of coordination amongst and between the various actors. Interviews with staff verify their knowledge of the Response Plan and its location.

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 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.

Policy 906 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, staff responsible for taking protection measures could articulate the requirements of the policy during interviews. Youth and staff interviews verified their knowledge of their rights against retaliation.

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.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. The facility does not conduct any administrative or criminal investigations. There were no PREA allegations made in the last 12 months.

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 does not 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 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.

Policy 906 requires the Superintendent or designee to inform the youth in writing, of the outcome, as required by the standard, unless the allegation is unfounded. The Superintendent and Facility PREA Compliance Manager verified this procedure during their interviews. There were no PREA allegations made in the last 12 months.

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 policies 104, 105, 142, and 907 state 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 termination and that criminal charges could 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 act(s) committed, among other considerations. Policy requires all allegations of sexual abuse to be reported to the Kentucky State Police regardless of whether the staff resigns or is terminated. The Superintendent confirmed the procedure in his interview.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 907 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.

Further, any volunteer or 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.

Policy 907 states that potential disciplinary action could include prosecution for engaging in any type of abuse or sexual activity or for making false accusations. 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 court system and/or Law Enforcement. There were no PREA allegations made in the last 12 months.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 905 states that a youth who reveals a history of sexual abuse will be offered a follow-up meeting with a medical or mental health practitioner within seven days. These youth are identified, monitored, counseled, and provided appropriate services.

Interviews with medical staff confirmed that services are provided if requested by a youth. Facility policy strictly controls the dissemination of information related to sexual victimization or abusiveness of youth on an as "need to know" basis. Staff 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.

Policy 905 require access to unconditional, immediate emergency medical and mental health services at no cost to the youth or family, not only for youth victims of sexual abuse, but for all youth in the facility. Although there were no youth victims of sexual abuse during the prior 12 months, facility policy requires that the youth victim be provided with information regarding STD prophylaxis. Medical staff reported that this would 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.

There were no youth victims of sexual abuse at this facility during the prior twelve months. Policy 905 requires any youth victim be provided with ongoing medical and mental health services.

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.

Policy 909 meets all of the requirements of the standard. There were no PREA allegations during the last twelve months that required a thirty day review. A form to be used in case of a sexual abuse allegation, was reviewed and met all of the requirements of the standard. Interviews with members of the Incident Review Team verified that the system is in place.

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. Policy 909 meets all elements of the standard.

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 2015 review which is posted on the State of Kentucky Department of Juvenile Justice Website, djj.ky.gov. This auditor was also provided with the reviews from 2011, 2012, 2013, and 2014. The agency has prepared an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. The report includes a comparison of the current year's data and has provided an assessment of the agency's progress in addressing sexual abuse.

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, djj.ky.gov, which 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.

G. Peter Zeegers 6/24/17

Auditor Signature Date