PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: April 7, 2016

Auditor Information			
Auditor name: Bobbi Pohlman-Rodgers			
Address: PO Box 4068, Deerfield Beach, FL 33442-4068			
Email: bobbi.pohlman@us.g4s.com			
Telephone number: 954-818-5131			
Date of facility visit: March 7, 2016 – March 8, 2016			
Facility Information			
Facility name: Northern Region Independence & Re-Entry Success Center			
Facility physical address: 461-63 Central Avenue, Newark, NJ 07107			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 973-648-7078			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Superintendent Darvin Bethea			
Number of staff assigned to the facility in the last 12 months: 24			
Designed facility capacity: 25			
Current population of facility: 11			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 14-21			
Name of PREA Compliance Manager: Nikisha Sanders		**Title:** Assistant Superintendent	
Email address: nikisha.sanders@jjc.nj.gov		**Telephone number:** 973-648-7081	
Agency Information			
Name of agency: New Jersey Department of Public Safety - Juvenile Justice Commission			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1001 Spruce Street, Trenton, NJ 08625			
Mailing address: *(if different from above)* PO Box 107, Trenton, NJ 08625-0107			
Telephone number: 609-292-1400			
Agency Chief Executive Officer			
Name: Kevin M Brown		**Title:** Executive Director	
Email address: kevin.m.brown@jjc.nj.gov		**Telephone number:** 609-292-1400	
Agency-Wide PREA Coordinator			
Name: Luis A. Valentin		**Title:** Chief of Employee Relations & Legal Affairs	
Email address: luis.valentin@jjc.nj.gov		**Telephone number:** 609-341-3196	

AUDIT FINDINGS

NARRATIVE

The Northern Region Independence & Re-Entry Success Center received an on-site PREA audit beginning March 7, 2016 by DOJ Certified PREA Auditor Bobbi Pohlman-Rodgers. Prior to the on-site audit, the auditor sent to the facility the Audit Notices in both English and Spanish to be posted by the facility. The facility provided the auditor, within 4 weeks of the audit, the Pre-Audit Questionnaire and a flash drive which contained all required documents. One week prior to the audit, the auditor contacted the facility and reviewed the daily itinerary and requested additional documents be made available on the first day of the audit. The request for documents included a list of staff and youth from which the auditor would select interviewees.

On March 7, 2016, the auditor met with Superintendent Darvin Bethea and PREA Compliance Manager Nikisha Sanders. The discussion centered around the on-site audit, the interviews, the tour, additional documentation review, and the process for the 30-day report (interim or final).

A tour of the facility was then conducted, and included the administration offices, kitchen, computer lab, classroom, waiting area, media room, basement, and the housing unit. Notices of the audit were posted in areas where both residents and staff could observe. Additionally, PREA information was seen in a variety of areas, including the residents day room, entrance alcove, and administration. Immediately following the tour, the auditor identified the specialized staff, random staff and random residents to be interviewed. There were a total of 10 specialized interviews, 9 random staff, and 10 random residents interviewed. The Executive Director, PREA Agency Coordinator, Investigator, and Human Resource staff were interviewed prior to this audit.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Northern Region Independence & Re-Entry Success Center, Home of the Stallions, is a three story building located in Newark, NJ. The community-based program provides transitional programming to young men ages 14-21 who have been paroled or completed a Community Program as a probationer. Parolees attend as a condition of their parole, and probationers attend when they have completed a community program and a release date has been identified.

The mission of the program is to assist residents with: educational & vocational exploration/placement, obtaining adequate housing, acquiring basic life skills and connecting residents with therapeutic community resources as they prepare for reintegration into their respective communities. The philosophy of the program is to provide comprehensive services to adjudicated residents under and within the authority of the Juvenile Justice Commission.

The facility houses a maximum of 25 residents. The resident housing is located on the third floor of the building. This floor contains two dormitory style living areas. There is a general bathroom and showers, both providing privacy from cross-gender staff viewing. There is a dayroom with a PREA board which the residents have assisted in decorating. There are two phones in this area that allow for outgoing calls. Residents have plenty of room to store their personal effects within the rooms and blinds have been added to the windows to allow for privacy.

Administrative offices are on the second floor along with a classroom. The first floor holds the kitchen, dining, and career services space. The basement provides a laundry room, food pantry and large storage areas. The laundry area is the only area accessible to residents. Outside there is a large basketball court for activities. Additionally, the property is completely fenced to allow for control of access to the building.

There are a number of services provided for both probationers and parolees that assist the residents in the transition back to the community. These include career exploration, health/wellness, life skills, family reunification, and independent living. While attending the program, residents are provided opportunities to visit their homes, school and work sites in accordance with the Juvenile Justice Commission's Preparation for Independent Living program. A resident may be assigned to stay at the program for up to 90 days; however the majority of are released within 21 days. Successful completion of the program includes completion of the transitional goals, appropriate behavior, and a recommendation from the Success Center transitional team.

While living here, residents are provided opportunities to obtain appropriate identification, such as copies of their birth certificate, voter registration cards, social security cards, and a state identification. Residents are enrolled in educational programs to include continuing the path toward a high school diploma or obtaining their General Education Diploma. Some are able to enroll in secondary programs or vocational certificate programs and some find gainful employment. Career development includes resume writing, researching a career path, or job interviewing skills.

Family reunification meetings are encourage and mediated. Substance abuse education classes and mental health services are available. Banking, budgeting, parenting classes and sex educational classes are also provided to residents. Residents preparing for independent living are offered classes in housing selection, budgeting, living expenses and other daily tasks associated with daily living. Community service activities are also encouraged.

Health and wellness is the last step to a residents release. They are provided assistance with obtaining health insurance, undergo a physical exam, immunizations and a wellness session.

There are four cameras at the facility. These monitor the outside of the building, including those who are seeking entrance. At the entrance is a PREA board with information for all staff and visitors. All visitors are required to sign in and out.

SUMMARY OF AUDIT FINDINGS

The facility staff provided information prior to, during, and immediately after the audit. A review of the documents, facility grounds, and systems found that the facility is compliant with PREA standards with a few challanges. The residents were well informed and able to articulate how to report any instance of sexual abuse or sexual harassment. Staff too were well informed as to how to repond to any knowledge, suspicion or information of sexual abuse or sexual harassment.

On March 8, 2016, the auditor concluded the on-site audit by meeting with the Superintendent and PREA Compliance Manager. The auditor reviewed the findings and requested additional information be provided within the next 21 days. The auditor specifically acknowledged the work of the facility PREA Compliance Manager. With the minimum length of stay being 3 weeks, Ms. Sanders strives to ensure that residents are provided information and services in a timely manner. It is noted that all staff are very dedicated to ensuring the safety of the residents at the facility.

During the 21 day period before the final report was written, the facility provided the remaining documents. After a review, this auditor finds that the facility is in full compliance with the Prison Rape Elimination Act.

Number of standards exceeded: 5

Number of standards met: 33

Number of standards not met: 0

Number of standards not applicable: 3

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.

Agency policy 14ED:01.02 addresses all components of the Zero Tolerance standard. The policy includes definitions of sexual abuse and sexual harassment that agree with the Prison Rape Elimination Act definitions. The policy includes prohibited behaviors regarding sexual abuse and sexual harassment. Sanctions for violation of the rules are included. The policy includes a description of the strategies and responses used to reduce and prevent sexual abuse and sexual harassment at the program.

Luis A. Valentin, Chief of Employee Relations & Legal Affairs, is the Agency PREA Coordinator and he is recognized on the organizational chart. During an interview, and subsequent contact with Mr. Valentin, his dedication to ensuring the state's compliance with the PREA standards is acknowledged. He has worked diligently to provide appropriate protection to the youth of New Jersey. He reports sufficient time to attend to these duties with the assistance of the Facility PREA Compliance Managers and a PREA team.

Nikisha Sanders, Assistant Superintendent, is the Facility PREA Compliance Manager. She reports sufficient time to attend to her duties regarding compliance with PREA standards. As the residents may only be a the facility for three weeks, her commitment to PREA standards is reflected in the work that she guides. The auditor is impressed with her work ethic and dedication to the program.

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.

The agency does not contract for the confinement of its residents with private entities or other entities, including other government agencies.

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 13ED:01.29 addresses staffing plans for secure facilities. Policy 09CP:09.01 addresses the specific supervision for this facility. Detailed in the policy are requirements for certain staffing patterns and posts during identified activities. The policy is clear as to the requirements of supervision.

The annual review of the staffing plan was conducted on February 5, 2016 and included Director of Community Programs, Human Resource Manager, Special Projects Manager, and the Chief of Employee Relations & Legal Affairs/PREA Coordinator. The review notes that prior staffing plan meetings were held in May 2015 and October 2015. There is a Direct Care Weekly Staffing Schedule as well as an FTE staffing plan for the program. The FTE shows that the facility is not functioning below staffing levels as determined by the agency.

There have been no noted deviations of the staffing plan. The facility will hold-over staff to ensure compliance with the staffing plan. Should deviations occur, these will be noted on the shift report as per interview with the Facility PREA Compliance Manager.

Current staffing has been based on 12 youth, as the average daily population in the past twelve months has been 11 youth.

Policy 14ED:01.02 addresses unannounced rounds within the facility by a Sgt. or higher and documentation was provided that confirmed this practice. The Superintendent issued a memo on October 29, 2015 to remind staff of the requirements of the unannounced rounds. These are documented on the PREA Management Rounds. A review of these forms found that rounds made from Nov 2015-February 2016 were random but not documented for each shift. Interviews with the Superintendent and the Facility PREA Compliance Manager indicated that the rounds were conducted but may not have been documented as required. During the 30-day time period before this report, the facility provided a plan to ensure that rounds will be appropriately conducted and documented. The Superintendent issued another memo on March 20, 2016 to begin a weekly review of these documents during the Management Team meetings.

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.

NJAC 13:103-11 addresses cross-gender searches in Community Programs and is mirrored in Policy 14ED:01.02. Both prohibit cross-gender searches except in emergent situations. Policy dictates that if conducted, they must be authorized and documented, including the reason for the cross gender search, as per NJJC Directive, Date 01/09/2013. An interview with the Facility PREA Compliance Manager confirmed their commitment to no cross-gender searches are permitted or conducted. On 12/10/2015, all staff received a refresher training on conducting resident searches. However, during the interviews, staff were unfamiliar with the gender of the staff searching a transgender youth.

Policy 09CP:09.01 addresses specific supervision of residents at this facility. This includes staff positioning when residents are in the showers or bathroom. Policy 14ED:01.02 prohibits the searching of a residents to determine genital status.

On 12/10/2015, all staff received a refresher training on conducting resident searches. On 3/14/2016, all staff received additional training on this topic and a copy of the signed roster was provided to the auditor.

There are posted notices when entering the 3rd floor housing area reminding female staff that they must announce their presence. Staff and resident interviews confirmed that announcements are made as required by a memo issued by the Superintendent on October 30, 2015.

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.

The Department of Education, Child Study Team case managers work with residents to identify any special circumstances which indicates the need for special education or related services and ensure that teach support is provided at the facility (NJAC 6A:14). The agency Office of Education provides for bilingual, ESL and English language education for youth, and these services are available at any time. The agency has available material in English and Spanish (most common non-English language identified in the facilities). Staff have access to request assistance from the New Jersey Department of Human Services, Division of the Deaf & Hard of Hearing for residents with limited or no hearing. Staff have access to request assistance from the New Jersey Department of Human Services, Commission for the Blind and Visually Impaired for residents who have limited or no sight.

Policy 14ED:01.02 prohibits the use of residents to translate for another youth. There is one identified staff interpreter for Spanish who has agreed to work directly with both a residents and their family as requested.

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.

Policy 14ED:01.02 addresses the specific requirements of hiring and promotion decisions of the agency. The State of New Jersey can consider criminal convictions and pending criminal charges for all applicants. The State of New Jersey may also access state and federal criminal databases to conduct background checks for all applicants. All employees are subject to Child Abuse Record Information (CARI) checks. However, they are prohibited by law from asking about any criminal arrest history, as an arrest unsupported by a conviction or an expunged or pardoned conviction may not be considered in considering applicants for non-law enforcement positions. The agency conducts 5-year background checks for all employees and contractors. A clear background check is a requirement for the issuance of JJC Identification Cards. Material omissions by an employee is subject to termination. A memo dated 8/20/2014 by Executive Direct Kevin Brown confirms background checks and material omissions. Three questions regarding previous misconduct is documented on the BI-001 form which is required for the completion of a background check.

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)

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There were no newly designed or substantial expansions or modifications of the existing facility. There was no installation or updating of a video monitoring system, electronic surveillance system, or other monitoring technology at this facility. This was confirmed in the interview with the Facility PREA Compliance Manager, who has reported that any changes or modifications would include consideration for the safety of the residents.

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)

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Policy 13OOI:01.04 requires the Office of Investigations to investigate allegations of sexual abuse. Policy 13OOI:01.29 requires a uniform evidence protocol is utilized that meets the requirements of the standard. Policy 14ED:01.02 requires protocols for informed consent, confidentiality, reporting to law enforcement, and reporting to child abuse investigative agencies. All residents are offered a forensic medical examinations, that include a Sexual Abuse Nurse Examiner and at no financial cost to the youth. A victim advocate is available as requested, and this advocate is available for all interactions during the examinations, investigatory interviews and for additional support and crisis services. An interview with the Investigator confirmed findings.

Forensic examinations are conducted through the Essex County SANE Program offered through the Essex County Prosecutor's Office. This is a component of the state-wide program to address the needs of sexual abuse victims. There are four SANE examiners in this county. In allegations where sexual abuse is made, the Essex County SART team is activated. This team includes law enforcement, nurse/physician examiners and victim advocates. Further information is available at www.njecpo.org.

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 14ED:01.02 requires an administrative and/or criminal investigation for all allegations of sexual abuse or sexual harassment. Policy 14OOI:01.29 details all types of sexual allegations shall be investigated and details the conduct of such investigations. All allegations of sexual abuse or sexual harassment are referred to the Office of Investigators for investigation. This information was confirmed with the Facility PREA Compliance Manager and Investigator. The PREA policy that identifies the investigation process can be found at the states website: www.nj.gov/lps.jjc.prea.html.

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)

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Policy 14ED:01.02A identifies training that is appropriate to gender for all staff and requires additional training if a transfer of staff assignment. The training provided to employees includes: the zero tolerance policy, fulfilling staff responsibilities, residents' rights, dynamics of sexual abuse/harassment, common reactions of victims, detecting and responding to signs of threatened and actual sexual abuse, inappropriate relationships between staff and youth, mandatory reporting duties, and other relevant laws regarding the age of consent. The agency maintains documentation of an employee's training through signature. The training addresses needs for both genders. A review of a sample number of files indicates training was completed by staff in 2013, 2014 and 2015. Training for 2016 is in progress.

All staff carry a PREA card issued by the Agency. This card describes all steps to be taken if a staff is made aware of any knowledge or information regarding an alleged sexual abuse incident. The card additionally covers confidentiality of information.

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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Policy 14HR:07.02: All volunteers and contractors receive training appropriate to their level of contact with youth. Those contractors, volunteers or interns who work directly with residents are required to complete the full PREA training that is required of state staff. This documentation is maintained through volunteer/contractor signature.

This facility has no volunteers and one contracted nurse who has received the staff PREA 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)

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At intake, all residents receive the brochure and handbook which details the zero-tolerance policy and how to report. Currently the agency provides comprehensive PREA education within 72 hours of intake, clearly exceeding the standard of comprehensive education within 10 days. At the time of screening, each residents receives information regarding the agency's zero tolerance policy and how to report incidents of sexual abuse or sexual harassment. Residents sign the Resident Acknowledgement Form for both the PREA Process Orientation and the PREA Video. This was confirmed through a sample of intake packets.

The New Jersey Department of Law & Public Safety JJC Brochure "Resident's Guide to the Prison Rape Elimination Act" is provided to youth. This guide details that reports can be made through the PREA Complaint Form, telling a staff, the sexual abuse hotline, and the Commission's Ombudsman. There is a box for the PREA Compliant Form at the door on the main floor of this building.

There is a PREA board in the resident day room and PREA information posted at the entrance to the facility.

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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Policy 14ED:01.02 identifies specialized training for investigators. In conjunction with the Moss Group, a select group of investigators has completed the Train-the-Trainer class. All investigators at the Office of Investigators have received appropriate training, which includes juvenile interviews, sexual abuse interviews, Miranda warning, Garrity warning, evidence collection and criteria for substantiating a case for administrative action or prosecution referral. The documentation of attendance is maintained through employee signature. Six investigators completed training on 06/18/2014 and a copy of these rosters was made available to the auditor.

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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All medical and mental health staff have completed specialized training to include signs of sexual abuse/harassment; preserving physical evidence of sexual abuse; responding to juvenile victims of sexual abuse/harassment; and how and to whom to report allegations or suspicions of sexual abuse/harassment. This training is in addition to required staff PREA training.

No forensic examinations are conducted on site.

All residents who report a sexual assault are transported to a local hospital where the Essex County Sexual Assault Response Team would be notified.

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)

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All of the required information is gathered at intake using the Intake Screening for Potential Sexual Aggressive Behavior and Vulnerability for Victimization and the Safe Housing Assessment form. These tools are used to determine a residents' potential to be vulnerable to victimization or to be sexually aggressive. All forms provide for questions/answers that meet the requirement of the standard.

There is a Reception Classification Committee who reviews these documents for risk factors. This is completed on day one of a resident's stay at the facility and is used in determining appropriate placement that provides for protections for vulnerable youth.

When placing residents for community programming, the resident is placed is a facility that is able to meet their immediate needs, and is hopefully close to where they will reside upon release.

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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corrective actions taken by the facility.

Policy 13ED:01.02A prohibits the placement of residents into a facility, assignment of roommate, education and work assignments based on LGBTQI status. Policy allows for placement of LBGTQI residents in room restriction, temporary close custody or a Behavior Accountability Unit as a means of keeping them safe only as a last resort. Policy allows for transgender and intersex residents to be able to shower separately from other residents upon request. The JJC Safe Housing Assessment is used for appropriate housing placement.

There is a Reception Classification Committee who reviews these documents for risk factors. This is completed on day one of a resident's stay at the facility and is used in determining appropriate placement that provides for protections for vulnerable youth. Policy 13ED:01.02A addresses housing and programming for transgender and intersex residents that is based solely upon their needs and the needs of the agency in providing safe housing for all residents. Individual needs are addressed through the Sex Offender Classification Committee (SOCC). Note that the name of the committee does not in any way mean that trangender and intersex residents are considered sex offenders.

Isolation is prohibited at this facility. Separation, if used, would be used only long enough for ensure the safety of the residents and to await transport.

With this program maximum time being 90 days, a review of transgender or intersex housing is not applicable.

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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The agency provides multiple ways for a residents to report allegations of sexual abuse or sexual misconduct, retaliation and staff neglect of responsibilities. Policy 14ED:01.02 addresses this requirement. Residents can report verbally, in writing as a juvenile statement or Request and Remedy to Investigators or Ombudsman, by phone to the Ombudsman/family/attorney, and by phone to the sexual abuse hot-line. Additionally, the agency has implemented a PREA Complaint form that is an emergency written process for reporting. There are two phones available for residents use. The hot-line goes directly to the New Jersey Coalition against Sexual Assault (NJCASA).

A memo dated February 23, 2015 was also issued to all residents detailing specific methods of reporting PREA allegations. This memo also details how a third-person report can be made. The agency has a specific Third Party Complaint Form which is available on their website.

Interviews with residents confirmed that they are aware of the multiple ways to report abuse if necessary.

Staff interviews confirm that they are aware of two ways to report outside of the facility: The DCP&P Child Abuse Hotline and the Office of Investigations.

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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Policies 14ED:01.27, 13ED:01.27 and 09CD:13.02 address the exhaustion of administration remedies. There is a grievance system known as a Request and Remedy which requires a response within 20 days. A Request and Remedy PREA Complaint form has been created to address emergency reporting through written format and requires an immediate response. Policy allows no time frame for reporting sexual abuse or sexual misconduct and there is no requirement for an informal process to be utilized prior to the filing of a Request and Remedy.

There is a third party complaint reporting form on the state website. The Facility PREA Compliance Manager has confirmed that any grievance reporting sexual abuse would be immediately forwarded to the Office of Investigators for an immediate review and investigation. A locked box was observed for these forms on the main floor of the building.

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.

New Jersey has a designated state-wide rape crisis care center – SAVE of Essex County. The center provides both education and advocacy and services to victims of sexual abuse. Residents are able to contact this center at any time whether in the program or from outside the program. The New Jersey Coalition against Sexual Assault has a variety of services to both survivors of sexual violence and their loved ones. Additionally, the facility has identified victim advocacy services in the surrounding counties. During the interviews, it was discovered that residents were not aware of these services. The facility updated their PREA education and a list of outside support services will now be provided to residents upon intake. All contact information is now posted on the bulletin boards for residents viewing.

Policy 09CP:13.02 provides that the Facility Administrator (Superintendent) shall make residents aware of the confidentiality of communication with these services. Residents are provided reasonable and confidential access to their attorneys or other legal representatives through telephone communication when they wish, through visits as scheduled and through the US mail at any time.

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.

Policy 14ED:01.02 will allow the agency to accept third-party allegations of sexual abuse or sexual harassment. The agency has created a 3rd Party PREA Complaint Form which is available on the state's website. This form allows for printing or fillable format, which can then be printed and mailed to the Commission. The address for the Commission is on the form. A hard copy of this form is available in the facility. All residents are advised that this form is another method of reporting by parents, guardians, or other identified outside persons. Interviews confirm that third-party complaints will be investigated.

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.

Policy 14ED:01.02 requires all staff to immediately report any incidents of sexual abuse or sexual harassment to both the agency and the Division of Child Protection and Permanency (DCP&P). Staff are prohibited from revealing information to anyone who does not have a need to know. Additionally, a memo was issued to all staff on August 14, 2014 that noted the following ways to report abuse: notification to the Supervisor, Superintendent, Assistant Superintendent, Shift Supervisor, or Office of Investigations (OOI). A memo dated August 20, 2014 requires reporting to the youth's attorney within 14 days, and to the parent or DCP&P (if guardian).

Additionally, staff are required to complete a Suspected Child Abuse Report which is then called into the DCP&P Child Abuse Hot-Line. Staff interviews confirm their knowledge of reporting requirements. Medical staff provide residents of their duty to report and the limitations of confidentiality. Additionally, medical staff is aware of the requirements of being a mandatory reporter.

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.

Policy 14ED:01.02 requires all staff to immediately respond in the event information is discovered that a resident is in substantial risk of sexual abuse. All staff are able to articulate steps to be taken.

Interview with Deputy Director confirms requirements of agency to provide protections to residents.

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.

Policy 14ED:01.02 requires the Office of Investigators to provide, within 72 hours, notification to a facility where an allegation has been made and to document such notification. There have been no allegations received from other facilities/agencies.

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 14ED:01.02 requires all first responders to separate the victim, preserve and protect the scene and to direct both victim and alleged perpetrator, if known, to not destroy evidence. All staff are trained as first responders. There have been no reports of sexual abuse in the past 12 months.

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.

The agency has a facility specific Sexual Abuse Incident Check Sheet that details the specifics of their Coordinated Response Plan. This form addresses all components of the standard. This checklist includes contact names and phone numbers for key staff to ensure notification is made in a timely manner. This includes all outside contact information as well.

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.

Bargaining unit contract allows for the removal of staff for purposes of protecting residents.

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 14ED:01.02 addresses the establishment of a system to protect residents from sexual abuse or sexual harassment or retaliation for reporting, and to protect staff from retaliation for reporting. A PREA Tracking Form is used and provides for status checks every 30 days and monitoring beyond 90 days as identified or needed. There was no review of a file for compliance as there have been no allegations requiring monitoring. The Facility PREA Compliance Manager was aware of all requirements in the event of a situation.

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 standard is N/A as this facility does not have protective custody.

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.

Policy 14OOI:01.29 requires an investigation of all PREA related incidents. All investigators at the agency level are sworn law enforcement and have received appropriate training as incidents by the standard. Investigators conduct all aspects of the investigation including evidence collection, interviews and review for prior complaints. They are in contact with prosecutors on a regular basis during an investigation. The policy prohibits the use of polygraph examinations as a condition for proceeding with an investigation. Policy and state law require all evidence to be maintained, including any handwritten notes, video, audio, etc. An interview with an Investigator previous to this on-site audit confirms knowledge, policy, and procedures.

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.

The agency does not impose a standard higher than a preponderance of the evidence for administrative cases. This was confirmed by an interview with the Investigator.

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 14ED:01.12 requires that the residents be informed by the Executive Director or designee of the outcome of an allegation. The designee is the Office of Investigations (OOI). Additionally, the Superintendent or designee is required to inform a resident of the status of a case against a staff member or other resident. Policy requires all notifications to be documented. This was confirmed through an interview with the Superintendent.

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.

Policy 14ED:01.02 states that termination is the disciplinary sanction for any staff member who engages in sexual abuse or sexual harassment against a youth. The policy requires notification to law enforcement for violations of sexual abuse or sexual harassment. There were no allegations of staff sexual misconduct at this facility.

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 14ED:01.02 addresses required responses when a volunteer or contractor has violated the agency zero tolerance policies, including reporting to law enforcement and licensing agencies (if applicable) and the prohibition of further youth contact. This facility has no volunteers and one contractor. There have been no allegations of contractor sexual misconduct at this facility.

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.

ADM 13:101 provides for the disciplinary process of the agency. It includes a formal disciplinary process and appeals process. Disciplinary actions for residents at this program could include discharge, and the reason for the discharge would be noted on Form 15CP:17-03A. Disciplinary sanctions are commensurate with the nature of the incident and take into certain factors prior to imposing the sanction. This information was confirmed through an interview with the Superintendent.

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 09MS:3.02 requires that any resident who reports prior victimization or prior perpetrated sexual abuse is to be immediately referred for medical or mental health counseling. While there is no current policy that addresses informed consent for resident's over the age of 17, the agency has provided a memo from the Executive Director that implements a policy change effective immediately. This memo is dated Otober 14, 2014. This will be incorporated into the agency policy during the next policy review process. Completed at classification, a referral is immediately sent if there is prior sexual victimizatioin or prior perpetrated sexual abuse. No youth were identified at this facility reporting a prior victimization or previously perpetrated sexual abuse that had not received a referral for services.

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.

Policies 13HS:01.01, 09MS:A.13 and 14ED:01.02 address immediate transfer to SANE facility for treatment for residents who report sexual abuse. The Coordinated Response Plan also addresses locations for SANE facilities. Medical and mental health staff is also advised and available for follow-up care upon the residents return. There are three SANE locations for this facility is Rutgers UMDNJ Hospital in Newark, Newark Beth Israel Hospital in Newark, and Moutainside Hospital in Glen Ridge. Medical staff report that they would refer to Rutgers UMDNJ Hospital in Newark.

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.

14ED:01.02 requires all residents who report victimization, regardless of when and when it took place, to be referred for treatment and counseling as identified. Services are consistent with the community level of care and would be provided by community physicians or the local hospital. Victims shall receive appropriate STD counseling and treatment as identified. Treatment services are offered at no cost to residents and within 14 days.

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 14ED:01.02 requires an incident review at the conclusion of an investigation of sexual abuse. The agency utilizes a Sexual Abuse Incident Review Form that allows for the documentation of all required components of the standard. There has been no allegations of sexual abuse at the facility and therefore no incident review was reviewed by the auditor.

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 data as per required by the DOJ SSV. There are no contracted facilities, so facilities only under their direct control is noted in the data collection. The agency maintains all files as per PREA standards. This information is maintained by the IT department in the Juvenile Information Management System (JIMS). This information can be access as required to provide reports.

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.

On March 4, 2016, the Executive Director issued a 2015 PREA report that details the agency's commitment towards compliance with PREA. The report details the steps taken by the agency, as well as the individual facilities in the calendar years 2014 and 2015. There is comparison data from 2014 and 2015. No specific information was redacted and therefore there is no statement of the nature of the material redacted from the report. A brief synopsis is noted on the agency website with a full report upon request.

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.

Data will be maintained for 10 years from the date of the initial collection and within the provisions of NJAC 15:3-2. Data collected will be maintained securely and will be encrypted and password protected to prevent unauthorized dissemination. The agency website contains a brief synopsis of the 2014 and 2015 report, with a full report available upon request.

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.

Bobbi Pohlman-Rodgers April 7, 2016

Auditor Signature Date