PREA AUDIT REPORT ☐ INTERIM ☑ FINAL
JUVENILE FACILITIES

Date of report: 06-25-16

Auditor Information			
Auditor name: Candy Snyder			
Address: PO Box 405, Custer SD 57730			
Email: Snyder@gwtc.net			
Telephone number: (605) 517-1747			
Date of facility visit: December 14 - 15, 2015			
Facility Information			
Facility Name: Burlington County Juvenile Detention Center			
Facility physical address: 620 Pemberton-Browns Mill Road Pemberton, NJ 08068			
Facility mailing address: *(If different from above)*			
Facility telephone number: (609) 726-7150			
The facility is:	☐ Federal	☐ State	☑ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility Type:	☐ Correctional	☑ Detention	☐ Other
Name of facility's Chief Executive Officer: Lynn Arnieri			
Number of staff assigned to the facility in the last 12 months: 38			
Designed facility capacity: 24			
Current population of facility: 12			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 11 to 18			
Name of PREA Compliance Manager: Supervising Officer Joe Ivanisik			
Email address: JIvanisik@co.burlington.nj.us			
Agency Information			
Name of agency: Burlington County Department of Corrections			
Governing authority or parent agency: *(if applicable)*			
Physical address: 54 Grant Street, Mounty Holly, NJ 08060-6000			
Mailing address:*(if different from above)*			
Telephone Number: (609) 265-5324			
Agency Chief Executive Officer			
Name: Mildred Scholtz		**Title:** Warden	
Email address: mscholtz@co.burlingotn.nj.us		**Telephone number:** (609) 265-5324	
Agency-Wide PREA Coordinator			
Name:		**Title:**	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE:

An audit of the Burlington County Juvenile Detention facility in Pemberton, New Jersey was conducted on December 14-15, 2015 by Candy Snyder, a certified PREA auditor, and assisted by Mark Snyder, an auditing assistant.

An entrance meeting began with facility staff Superintendent Lynn Arnieri and Supervisor Charles Goff. The PREA Coordinator for the jail, Sgt. Robert Inman, sat in on the meeting for observation purposes only. Warden Scholtz joined the meeting a short time later.

Following the entrance meeting, Lynn Arnieri, Warden Scholtz and Charles Goff accompanied the audit team on the facility tour. The auditor then began interviewing specialized staff. Suitable and private accommodations were made for the auditor to conduct interviews. The auditor was not limited in any way from speaking with staff or youth or inspecting any area of the facility. The auditor was given access to the facility at all hours of the day in order to conduct interviews with staff on all shifts. The superintendent and her staff were extremely polite and accommodating throughout the audit.

As BCJDC is a rather small facility and key staff hold multiple positions. Lynn Arnieri was interviewed as the Superintendent, Human Resource Manager, the PREA Coordinator and the facility administrative investigator.

The auditor conducted a review of the application and hiring process and employee background checks.
The auditor reviewed investigative files. There was one sexual assault allegation case reported within the past year. It was investigated by the Department of Children & Families Institutional Abuse Investigation Unit and determined to be unfounded. Investigative files were reviewed and were handled appropriately and per the standards.

Ms. Arnieri provided a copy of the staff schedule. The auditor randomly selected ten (10) staff and conducted interviews of staff covering all shifts, varying degrees of longevity, diverse job classifications and staff who worked within varying areas of the facility. The auditor asked specialized questions of those line staff that perform screenings, perform searches, who are first responders, and staff who conduct the intake process.

The auditor completed interviews of 11 youth with varying lengths of stay and youth from both housing areas. There were no residents who were disabled or who were limited English speaking to be in interviewed and there were no residents who identified as LGBTI. The facility has not implemented a screening process and therefore there were no youth who were screened and had identified previous sexual abuse prior to placement. The facility states that it does not use isolation and this was confirmed through direct observation and through interviews.

An exit briefing was held with the facility Superintendent, the Warden, and the Supervising Officer. Sgt. Inman, the PREA Coordinator from the jail, was present as an observer. The auditor provided a preliminary finding of each standard with the caveat that this was subject to change as the auditor continued to review documents, may have questions to be answered and prepares the interim report. The auditor thanked the BCJDC staff for their hard work, their hard work yet to come, their commitment to follow the Prison Rape Elimination Act and most importantly, their dedication to and caring for the youth under their charge.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The facility is located in Pemberton Township in Burlington County, New Jersey. The original facility was constructed in 1968 with a building expansion project completed in 1991. The facility is comprised of two buildings and a secure, fenced-in outdoor recreation area. The main building consists of administrative areas, intake area, dayroom, dining room, kitchen, and two housing wings – one for male youth and one for female youth. Wing A for female youth has seven (7) single rooms that consist of a bunk and a combination unit toilet/sink. The combi unit is situated within the room so that the youth has privacy when toileting. There are two showerheads within the girls' shower room. However, staff and youth confirm that they are showered singly. Wing B is for male youth and has 17 single rooms. The room layout in the boys' rooms are the same as the girls' rooms. On the boys wing there are three showerheads within the boys' shower room. However, boys are showered two at a time in the presence of a male officer unless special considerations are made for showering singly.

There is a gymnasium for indoor recreation and a modular building that was added in 2000 to increase space for educational services. Throughout the tour of the facility, the auditor noted PREA posters and the required posted Audit Notice.

SUMMARY OF AUDIT FINDINGS:

The facility staff have been working on implementation of PREA compliance measures over the past year for the Burlington County Juvenile Detention Center. Although not all standards were initially fully met at the time of the on-site portion of the audit, staff and youth were aware of PREA and staff were committed to youth safety. Most importantly when asked, all youth stated that they felt safe at BCJDC.

Following the on-site portion of the audit, BCJDC entered a corrective action period. The facility staff worked diligently to address every standard and ensure that the facility not only enacted the processes required by the standards, but devoted themselves to meeting the standards with the intent behind them – making improvements to ensure sexual safety for their residents and creating a culture and open dialog with the youth about sexual safety.

Number of standards exceeded: **0**

Number of standards met: **39**

Number of standards not met: **0**

Number of standards not applicable: **2**

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.

The Superintendent was still working on the PREA policy for BCJDC at the time of the on-site portion of the audit. The auditor reviewed relative policies that were active, but not specifically the PREA policy mandating zero-tolerance and outlining the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Most of the procedures for following the standards were enacted through directive and standard operating procedure and staff have been following them for some time.

The facility had designated the Superintendent as the PREA Coordinator and she is working diligently to address every standard in both policy and procedure. She has the authority to develop, implement and oversee the efforts and was very responsive throughout the corrective action period.

CORRECTIVE ACTION: The auditor required a signed, active copy of the facility PREA policy that mandated zero-tolerance and outlines the facility's compliance efforts. The auditor appreciated the Superintendent's method of developing procedures first, conducting an audit to review procedures and then implementing the policy. The PREA policy was provided to the auditor on June 24, 2016.

With the understanding that this is a small facility and multiple roles are filled by single individuals, the auditor recommended that another staff be designated as the facility PREA Coordinator. The Superintendent is already filling multiple roles. This recommendation was made during the exit interview and by December 21, 2015 the Superintendent had assigned this duty to Supervising Officer Joe Ivanisik. Additionally, on December 21, 2015 Mr. Ivanisik enrolled in the National Institute of Corrections course "*Coordinators' Roles and Responsibilities*".

Standard 115.312 Contracting with other entities for 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 not applicable. The facility does not contract for the confinement of its residents with other private agencies/entities. However, as the facility has an informal "courtesy hold" process with Ocean County Juvenile Detention Center, the auditor recommends that you complete a letter with a statement that is signed by each Superintendent that reads as below:

> *The (receiving) Juvenile Detention Center will comply with the Prison Rape Elimination Act of 2003 (Federal Law 42. U.S.S. 15601 ET. Seq.), and with all applicable PREA Standards related to PREA for preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within your Facilities/Programs/Offices owned operated or contracted. The (receiving) Juvenile Detention Center acknowledges that, in addition to "self-monitoring requirements" the (sending) Juvenile Detention Center may conduct announced or unannounced, compliance monitoring to include "on-site" monitoring. Failure to comply with PREA, including PREA Standards may result in termination of the courtesy hold agreement between the (receiving) Juvenile Detention Center and the (sending) Juvenile Detention Center.*

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.

The facility completed a consolidation plan that was approved by the State of New Jersey Juvenile Justice Commission in July 2015. Within this plan it included camera surveillance systems, staff coverage and adequacy of supervision. Although this plan was completed for other reasons, it very thoroughly addressed any staffing issues within the facility and meets this standard. The document outlines the additional staff that were hired by BCJDC in order to ensure that they can maintain and adequate level of staffing with the consolidation of Cumberland and Burlington Counties. This process of evaluation of staffing levels must be completed in future years to continue to remain in compliance with this standard. The auditor did note that staffing ratios have been met over the past year.

The facility conducts strip searches upon intake with a single staff member alone with the youth. The auditor recommended that a change in procedure be immediately initiated which allows for a second staff member to be present that solely has view of the staff member conducting the search, but does not have view of the youth. This procedure will allow for both protection of the youth and protection of the staff from false allegations while still maintaining the youth's privacy.

At the time of the on-site portion of the audit the facility did not conduct and document intermediate or higher level staff rounds and did not have this procedure outlined within any policy.

CORRECTIVE ACTION: The auditor required the BCJDC to include in its formal PREA policy the practice of intermediate-level or higher level supervisors conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The auditor required that the practice be implemented for night shifts as well as day shifts. The policy must also prohibit staff from alerting other staff members that these supervisory rounds are occurring. In discussions with the Warden and the Superintendent, they will begin implementing document rounds performed by the Superintendent and managers from the Burlington County Jail staff immediately. The auditor required documented instances of these rounds occurring. On March 9, 2016 the Superintendent provided the unannounced log that recorded multiple unannounced rounds that had been conducted since the on-site portion of the audit in December. Those rounds occurred during varying times to include evening hours and weekends. On June 24, 2016 the BCJDC provided the signed policy formally requiring unannounced rounds.

In regard to the initial entry and strip search of a youth, the facility immediately implemented the procedure of requiring the staff member conducting the strip search to reposition outside of the shower area so that they can be viewed by the staff member in the control room.

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.

The facility does not conduct cross-gender strip searches, cross-gender pat-down searches or cross-gender visual body cavity searches. This was verified through interviews with both staff and youth. The facility did not have an exigent circumstance log in the event of an emergency in which to document a cross-gender search. The Consolidation Plan did state that there were three instances in 2014 in which there were no female staff on shift, yet there were female youth housed at the facility. An emergency event could arise in which a male would have to perform a search of a female youth during an exigent circumstance.

The facility has good policies and procedures in place that enable residents to shower, toilet and change clothing without staff of the opposite gender viewing them naked. Although staff of the opposing gender are very rarely on the youth's housing wing, they do announce their presence when entering. These procedures were confirmed also through staff and youth interviews. There have been no instances of transgendered or intersex residents admitted to the facility. However, the BCJDC staff were aware of the responsibility of determining sex solely through professional conversation or through medical records or through part of a broader medical examination by a medical practitioner.

The facility prohibits cross-gender searches, but still must provide cross-gender search training in the event an exigent circumstance occurs. In addition, there was no documented training of how to properly conduct a search of a transgender or intersex resident.

CORRECTIVE ACTION: The auditor required that the BCJDC provide all staff with cross-gender search training, when to conduct such searches and to document these searches on an exigent log if they take place. The auditor requested the training records to verify the training as well as a sample of an exigent circumstance log that will be used. The requested verification of training was provided to the auditor on May 10 and June 27, 2016. A sample of their exigent circumstance log was provided to the auditor on May 17, 2016

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.

This standard requires that the facility administrator think ahead of how to effectively handle situations involving a youth who is limited English proficient or may have disabilities so that they may fully participate in protection efforts. The BCJDC typically do not encounter this, but have identified a staff member who is bilingual to assist. He speaks both English and Spanish. It is likely that the resident who does not speak English would predominantly be Spanish-speaking in this area. However, this cannot be assured. There have been no instances during this reporting period where resident interpreters, readers or other types of resident assistants were needed or used. The facility does not use residents to interpret for other residents.

CORRECTIVE ACTION: The facility must have an interpretive service available 24-7 that can assist in the intake process, screening process, education on how to report and if need be, translate during the investigative process. The Superintendent stated she would check on the Language Line that is used by the New Jersey Juvenile Justice Commission. In addition, they will check with the education department to determine which services are available for learning impaired students or those that may be visually or hearing impaired. Once resources have been identified, they will ensure that all staff have been trained on the availability of these services and that the contact numbers are posted in easily accessible areas for staff. They will provide the auditor proof of services and photographic evidence that the contact information is prominently displayed in the intake area, the medical office and the supervising officers office. Verification of 24-7 interpretive service as required by the auditor was provided on May 26, 2016.

Standard 115.317 Hiring and promotion decisions

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

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

The facility has performed background checks at the time of employment of new hires. They had not been performing Child Abuse Record Information (CARI) checks at the time of employment. They also had no requirement to run the background check again every five years. They did not included the required three questions at the end of their application nor require new hires to affirm that they have a continuing duty to report.

CORRECTIVE ACTION: The auditor required the BCJDC to run a criminal background check and a CARI check for all existing employees. CARI checks must be ran for all employees that were hired after August 20, 2013. They must also develop a process for ensuring that the criminal background check is completed again every five years or if an employee is promoted into a new position. The auditor required that the three questions relating to this standard be asked during the hiring process as well as a continuing duty to report. On February 25, 2016 the Superintendent provided the new BCJDC application that included these questions as well as a signed acknowledgement by the applicant that if hired they understood they have a continuing duty to report sexual misconduct or any adverse contact with law enforcement. On April 11, May 2, May 5 and June 7, 2016 verification of background and CARI checks were provided to the auditor. The BCJDC also required their IT department to develop an email notification system alerting them when an employee was due for their five year background check to be ran again.

Standard 115.318 Upgrades to facilities and technology

- ☐ 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 have been no major expansions or modifications at this facility. The administrators consider the ways in which to enhance their efforts and abilities to protect residents from sexual abuse through the use of electronic monitoring and video monitoring. They have camera systems in all key areas. Additionally, they have electronic monitoring in which they can hear (but not record) the conversations within rooms from the control room. They recently installed a new DVRS so they could extend the retention times of recordings.

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.

As soon as the administrator is notified of a sexual abuse the protocol is to call both the Division of Child Protection and Permanency (DCPP) and the Burlington County Prosecutor's Office. The Burlington County Prosecutor's Office Sexual Assault/Child Abuse Unit (SACA) uses special investigative techniques, as well as a different investigative and prosecutorial approach to successfully investigate, prosecute and care for the child victim. Detectives receive specialized training in interviewing the victims of sexual assault and physical child abuse. They have a multi-disciplinary approach that couples the detectives and prosecutors with mental health agencies, DCPP and educational and medical professionals. The purpose of this approach is to minimize the impact of the criminal investigation on an already traumatized child. The prosecutor's office has a SART/SANE Coordinator that is responsible for providing for the medical forensic exams to victims of sexual assault. The coordinator is the liaison to the four participating SART hospitals, maintains chain-of- custody for all evidence, writes policies and procedures, maintains case files, communicates with law enforcement agencies and oversees the response of the Sexual Assault Response Team. In addition to conducting exams of victims who are 13 or older, SANE nurses conduct acute pediatric exams as well. Ten nurses are now trained to do pediatric assault exams. These exams consist of evidence collection in cases where an assault occurred within 5 days of the exam.

At the time of the on-site portion of the audit the facility had not specifically set up a Memorandum of Understanding (MOU) with a local advocate from a rape crisis center. However, Contact has an agreement with the Bulrington County in connection with the SACA Unit. Contact is the local advocacy agency in Burlington County. They have trained advocates that provide counseling to survivors. They also provide accompaniments to Burlington County hospitals, police stations and courts.

CORRECTIVE ACTION: The auditor required the BCJDC set up an MOU with Contact for advocacy service. The auditor also required staff receive additional training regarding the call to Contact to ensure an advocate was assigned to accompany a sexual assault victim to the hospital. On April 19, 2016 the auditor received updated training acknowledgement forms for all staff. The auditor received verification that the Board of Freeholders approved the formal MOU with Contact on June 14, 2016. The auditor verified with Contact that they would provide services.

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.

The procedures are in place to always notify the prosecutor's office and DCPP for every incident of sexual abuse. However, there must be a written policy that states all allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. In addition, you must publish this policy on your website.

CORRECTIVE ACTION: The auditor required written policy that states all allegations of sexual abuse or sexual

harassment are referred for investigation. On June 24, 2016 the BCJDC provided their policy on investigations to the auditor with an effective date of June 24, 2016. The auditor verified the enacted policy was posted on their website.

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.

The BCJDC provides PREA training to all staff. However, the facility only had a roster with signatures that says PREA Training. They must document, through employee signature, that employees understand the training they have received and list the components of the training. During the staff interviews the auditor had the perception that staff have had limited experience effectively communicating with LGBTI youth and have not received training in how to professionally communicate with this population.

CORRECTIVE ACTION: The auditor required documentation that outlined specifically what was taught in their PREA classes and that staff attest they understand the training that they have received through their signature. The BCJDC only had PREA training rosters. The auditor required signature sheets in which the staff attest to understanding the 11 items outlined within this standard. The auditor specifically recommends training on effectively and professionally communicating with LGBTI youth. On March 10, 2016 the BCJDC staff provided an outline of LGBTI training to be implemented. Verification of training to all staff was provided to the auditor on April 19, 2016.

Standard 115.332 Volunteer and contractor training

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

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

The BCJDC provides PREA training to volunteers and contractors. However, the facility only has a roster with signatures that says PREA Training. They must document, through signature, that volunteers and contractors understand the training they have received and list the components of the training.

CORRECTIVE ACTION: The auditor required the facility outline specifically what was taught and volunteers must attest that they understand the training that they have received through their signature. It cannot just be a roster that says PREA Training. The auditor required they provide signature sheets in which the volunteers and contractors attest to understanding the items trained. On April 22, 2016 the facility provided verification of training for volunteers and contractors.

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.

The facility provides residents information on BCJDC's zero tolerance culture regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. This was evident through the interviews with youth. They also provide additional comprehensive education within ten days of intake in person. This more comprehensive training is completed by the social worker. This more comprehensive training includes their right to be free from sexual abuse and sexual harassment, to be free from retaliation for reporting such incidents, and regarding the BCJDC's policies and procedures for responding to such incidents. This information is continuously and readily available through posters throughout the facility as well as in the BCJDC Juvenile Rule Book.

The BCJDC is required to maintain documentation of resident participation in both of these education sessions. The auditor was unable to view such documentation.

CORRECTIVE ACTION: The auditor required the facility outline specifically what is taught and residents must attest that they understand the training that they have received through their signature. This documentation is required for both the initial, basic training to residents done upon intake, and the more thorough comprehensive training completed by the Social Worker within the first ten days. On January 28, 2016 the Superintendent provided information regarding their updated youth training program. On March 2, 2016 the Superintendent provided signed verification forms that all youth had been trained in both the initial training and that the Social Worker used a video provided by Idaho for more in-depth PREA training to youth.

Standard 115.334 Specialized training: Investigations

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

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

The Burlington County Prosecutor's office conducts sexual abuse investigations and they have received training in conducting such investigations in confinement settings. Although the BCJDC itself does not conduct sexual abuse investigations, the Superintendent completed the NIC course *PREA: Investigation Sexual Abuse in a Confinement Setting* on December 15, 2015 and the PREA Compliance Manager completed the course on April 21, 2016. They will be the administrative investigators for the facility and this specialized training helps them to identify the initial information so that it may be properly referred to the prosecutor's office.

Standard 115.335 Specialized training: Medical and mental health care

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

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

Through interviews with the heath services administrator it is apparent they are knowledgeable in how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. However, the facility did not maintain documentation that medical and mental health practitioners have received the specialized training.

CORRECTIVE ACTION: The auditor required documented evidence that medical and mental health practitioners have received specialized training as required by the standard. On April 26, 2016 the Superintendent provided certificates for social services staff who completed the NIC course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* on April 19, and April 25, 2016. On March 29, 2016 the nurse completed the Health Stream course *PREA* for health care providers.

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.

The BCJDC has not implemented a screening process. The auditor reviewed the screening tool that the BCJDC plans to implement and their process for implementation.

The standard requires that usually within 24 hours but no later than 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the facility maintains and uses information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The facility has a draft screening that had not been implemented at the time of the on-site portion of the audit. Although the draft screening tool asks the evaluator to note if the youth presents a gender nonconforming appearance/behavior, the screener does not ask the youth if they identify as lesbian, gay, straight, bisexual or transgendered. Typically, youth have no issues answering this screening question when asked directly and professionally.

CORRECTIVE ACTION: The auditor required the facility provide documented evidence of screenings performed on all youth. The auditor recommended changing the screening tool. Instead of the screening looking for gender non-conforming appearance or behavior that the screener asks directly of the youth "Do you identify as gay, lesbian, straight, bisexual or transgendered?" or some similar question in an appropriate, professional way. On June 21, 2016 the facility provided documented evidence of all youth at the facility screened. The facility did provided an updated screening tool as well.

Standard 115.342 Use of screening information

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

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

BCJDC is doing a good job with placements based on all information obtained to make housing, bed, program, and education for residents with the goal of keeping all residents safe and free from sexual abuse. However, they were not using a screening tool and residents have not been formally screened utilizing the screening instrument. The facility has had no transgender or intersex residents, but interviews indicate that a transgender or intersex resident's own views with respect to his or her own safety would be given serious consideration. It is also indicated that transgender and intersex residents will be given the opportunity to shower separately from other residents. The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The facility indicates through interviews that they will consider on a case by case basis assignment to a living unit whether the a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Facility procedure is to manage a resident's room placement rather than using isolation as a means for protecting the resident's safety.

CORRECTIVE ACTION: The auditor required BCJDC to screen all residents utilizing the screening tool to ensure appropriate housing decisions are made. On June 21, 2016 the BCJDC provided documented evidence of all youth at the facility screened.

Standard 115.351 Resident reporting

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

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

BCJDC provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, or retaliation. Youth often speak with the social workers and have ready access. They can write a grievance (grievance forms are in the back of the resident rule book). Social Workers assist them in their calls and they can call whomever they choose. They can speak with the nurse privately at any time by simply making the request. They also can speak with the Superintendent by making the request to any staff.

Youth reported feeling very comfortable reporting directly to their staff or another person within the facility. They reported there is a grievance process. The staff accepts reports made verbally, in writing, anonymously, and from third parties and promptly documents any verbal reports. The facility provides residents with access to tools necessary to make a written report.

CORRECTIVE ACTION: The auditor required BCJDC provide a phone for resident use with access to an outside agency that is willing to accept calls from facility residents. Without this, the facility did not have at least one method for reporting to a public or private entity or office that is not part of the BCJDC. On April 4, 2016 the facility provided verification that a phone with a hotline number to Contact for reporting sexual abuse is available to the youth.

Standard 115.352 Exhaustion of administrative remedies

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

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

Residents may submit a grievance alleging sexual abuse or harassment without submitting it to a staff member that is subject of the allegation. The grievance form is available and a blank form is also in the back of the youth's "Juvenile Rule Book". The youth does not have to complete any other prior steps in order to submit a grievance for an allegation of sexual abuse. There is no time limit on when a youth can submit a grievance regarding an allegation of sexual abuse. Staff and youth interviews confirmed their knowledge of how the grievance process can be used to report sexual abuse and sexual harassment.

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.

BCJDC did not have an MOU with a child advocacy organization. The BCJDC provides youth with reasonable and confidential access to their attorneys and parents. In addition, all youth interviewed reported that they had contact with their families regularly. If the youth is involved with the Department of Children and Families, they may already be assigned a Care Management worker who assists them in accessing services through Care Management Organizations (CMO's) that provide a range of treatment and support services to children.

CORRECTIVE ACTION: The auditor required the BCJDC provide access to an outside support service agency. The auditor required a MOU with this agency. On June 14, 2016 verification of the MOU with Contact was provided to the auditor. The auditor required photographic evidence of posters on how to access this service. This was provided on April 4,' 2016. The auditor required an updated handbook that includes contact information for this service. On May 2, 2016 the updated handbook with the information for Contact was provided.

Standard 115.354 Third-party reporting

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

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

The agency has not identified a method to receive third-party reports of sexual abuse/harassment nor distributed the information publicly on how to report sexual abuse and sexual harassment on behalf of a resident.

CORRECTIVE ACTION: The agency must post on their website how to report sexual abuse and sexual harassment on behalf of a resident. On June 24, 2016 the auditor verified that the third party contact information was on the BCJDC website at http://www.co.burlington.nj.us/1176/Juvenile-Detention-Center. The auditor recommends including this information in a correspondence or information it supplies to parents and guardians of residents as well as posting this contact information in the visit area.

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.

BCJDC requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Apart from reporting to designated supervisors or officials and designated State agency, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials as well as to the designated State service agencies. Such practitioners are required to inform the residents at the initiation of services of their duty to report and the limitation of confidentiality.

The staff reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to designated investigators. Upon receiving any allegation of sexual abuse, the Superintendent or designee promptly reports the allegation to the DCPP, the prosecutor's office, and to parents or legal guardian.

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.

Through interviews with the Superintendent and random staff there is evidence to support that the facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. There have been no instances that a resident was subject to risk of imminent sexual abuse.

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.

Through interviews with the Superintendent and random staff there are procedures in place to appropriately act upon receiving an allegation of sexual abuse of a resident while at another facility with such action initiated no later than 72 hours and actions documented. Many staff, but not all, stated the notification must be from Superintendent to Superintendent. The auditor recommends that this training to staff be reinforced. There was a few staff that were unaware of this requirement. There have been no instances of these allegations received regarding abuse at other facilities.

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.

BCJDC staff seemed to be well versed in these procedures and were aware of all elements of this standard (separate alleged victim/abuser, preservation and protection of crime scene, to include collection of physical evidence as soon as possible, including the request of the victim not to take any actions which could destroy any physical evidence). Interviews with random staff confirmed knowledge of these procedures.

Standard 115.365 Coordinated responses

- ☐ 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 did not have a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Although staff interviews and interviews with the Superintendent indicate staff are aware of their responsibilities to coordinate responses within the facility, the response plan must be in writing. The facility has a PREA Response palm card that staff can readily use in the event of an assault.

CORRECTIVE ACTION: The auditor required that their coordinated response plan be in policy. On June 24, 2016 the auditor received the effective PREA policy. In Part 5 of this policy is a comprehensive coordinated response plan.

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.

There are no barriers preventing the Superintendent from removing alleged staff, volunteer, or contractor sexual abusers from contact with residents pending the outcome of the investigation and a determination of discipline. The facility staff are represented by Communications Workers of America, AFL-CIO. There is nothing within the collective bargaining agreement that precludes BCJDC administration from removing an employee from contact with youth while an incident is under investigation or terminating employment after a substantiated allegation against the employee for sexual abuse.

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.

The facility did not have a written policy related to protection against retaliation. The Superintendent and the Supervising Officer is charged with monitoring for retaliation. Should any other person who cooperates with a sexual misconduct investigation express fear of retaliation appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. There have been no instances of alleged sexual harassment or abuse and hence no incidents of retaliation. The auditor recommended that a logbook be kept logging each time contact is made with a resident or staff to follow-up regarding retaliation.

CORRECTIVE ACTION: The facility must establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members are charged with monitoring retaliation. On June 24, 2016 the auditor received the effective PREA policy for the BCJDC. In Part 6 of this policy is a comprehensive plan for protection from and monitoring for 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 standard is not applicable. The facility does not use segregated housing of residents as a means to keep them safe from sexual misconduct. Interviews confirmed the prohibition of segregated housing for this purpose. Youth have individual sleeping rooms and when they are out of their room they are in the direct supervision of staff. Adequate precautions can be taken such as keeping the youth in more close proximity of staff to keep them safe.

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.

The auditor reviewed agency investigative files. The facility had one unfounded incident of sexual abuse that was investigated by The Department of Children & Families Institutional Abuse Investigation Unit. The incident was properly investigated and documented as outlined by PREA standards. The facility cooperated with outside investigators and remained informed of the investigation progress. The resident had departed the facility and the investigation was not terminated due to the departure of the alleged victim.

Administrative investigations include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports that will include physical/testimonial evidence, credibility reasoning assessments and investigative facts and findings. All written reports will be retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The Superintendent and the PREA Compliance Manager are designated as the facility administrative investigators, but had not completed specialized training. Upon recommendation of the auditor they completed the course *PREA: Investigating Sexual Abuse in a Confinement Setting.* The Superintendent's quick action in completing the course on December 15, 2015 once again shows her dedication to meeting all standards. The PREA Compliance Manager completed the course on April 21, 2016.

Standard 115.372 Evidentiary standards 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 BCJDC uses no standard higher than a preponderance of evidence in making a determination of alleged sexual abuse/harassment. Through interviews with the Superintendent it was stated they use no standard higher than the preponderance of evidence in making final determinations of sexual abuse/harassment.

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.

The facility had no method for documenting informing residents as to whether the allegation was substantiated, unsubstantiated or unfounded. There were no reported incidents (other than the one in which the resident had already departed the facility). The staff were not aware of the requirement to notify the resident nor were they able to identify a way in which to document this notice.

CORRECTIVE ACTION: The auditor recommended that the facility develop a form that can document notice to a resident of the outcome of a sexual abuse or sexual harassment investigation. On March 10, 2016 the Superintendent provided the form that the facility will use to document outcomes of investigations to residents.

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.

All staff members who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions. No staff has violated agency sexual abuse, harassment or retaliation policies. Interviews conducted with the Superintendent verified that there had been no substantiated allegations at the facility. Interviews also confirmed that this standard would be followed should disciplinary measures be required including a report to law enforcement and relevant licensing authorities should termination and/or resignation of staff occur.

Standard 115.377 Corrective actions 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.

Any contractor or volunteer who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions including termination of service. There have been no contractors or volunteers who have been accused of sexual misconduct.

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.

For incidents of youth-on-youth sexual abuse, sexual harassment or retaliation, administrative sanctions will be handed out following the formal disciplinary processes and applied commensurate with the level of infraction. A youth's access to general programming or education is not conditional on receiving interventions designed to address/correct underlying reasons or motivations for abuse.

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.

At the time of the on-site portion of the audit they were not conducting a screening for prior sexual victimization or previously perpetrated sexual abuse. Once the screening tool has been implemented they will offer a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening and document the offer and whether the resident desires to have follow-up with a medical or mental health practitioner on the bottom of the screening form. The facility will obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting for residents over 18 years of age.

CORRECTIVE ACTION: The auditor required verification that they were screening youth for prior sexual victimization or previously perpetrated sexual abuse with the documented date, the offer of a follow-up meeting with a medical or mental health practitioner was made and whether the resident desired follow-up care. On June 21, 2016 the Superintending provided verification that all youth were screened. Part 2 of the PREA policy requires that all youth screened who identify prior sexual abuse or perpetration of sexual abuse are offered follow-up services with a qualified medical or mental health care provider. The auditor required a sample of the informed consent form for disclosing reports of previous sexual abuse by residents over 18 years of age. This form was provided to the auditor on April 18, 2016.

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.

The facility provides access to emergency medical and mental health services. In the event services after hours are not available by the facility medical and mental health staff, residents would be taken to either Virtua Hospital in Mt. Holly or Lourdes Medical Center of Burlington County in Willingboro. These services have not been used during the audit review period.

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.

The facility will require that medical and mental health evaluations and treatment is offered at no cost to sexual abuse victims and abusers. The health services administrator stated that in many instances services are accessed through the Department of Children and Families, Care Management Organizations (CMO's) that provide a range of treatment and support services to children. Once a Care Management worker is assigned, those services would follow a resident that is transferred or discharged. If a youth will be taken to the local hospital, tests for sexually transmitted infections and pregnancy will be offered there.

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.

The facility did not have a plan set up to conduct formal sexual abuse incident reviews following each sexual abuse investigation specifically answering the questions posed within the standard. The auditor recommended a consistent date each month is set for the review of any incidents from the previous month. This review should include upper-level staff, supervisors, investigators, medical and mental health staff.

CORRECTIVE ACTION: The auditor required the facility devise a means of documenting a formal review process and ensure a review is completed within 30 days after each incident, unless the incident is unfounded. On March 31, 2016 the Superintendent provided the form that will be used for their review process. The review process is outlined in Part 7 of the BCJDC PREA policy.

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 facility did not collect data for allegations of sexual abuse based on incident reports and investigative files.

CORRECTIVE ACTION: The auditor required a spreadsheet or some other documentation of their aggregate data. The facility must provide 2013, 2014, and 2015 data. On June 24, 2016 the Superintendent provided aggregate data as requested.

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 had not held an annual review of data or prepared an annual report. This review should be attended by all upper level managers and should report findings and corrective actions as well as the progress made through the previous year in addressing sexual abuse.

CORRECTIVE ACTION: The facility shall prepare an annual report assessing the facility's progress in addressing sexual abuse and post this annual report on the agencies website. Senior level managers shall review all incidents for corrective action measures. On June 24, 2016 the Superintendent provided the Annual Report.

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)

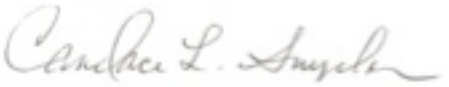
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations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

The facility had not posted data to their website. Data collected is retained via limited access and through a secure server for at least ten (10) years.

CORRECTIVE ACTION: The facility must post PREA related data on the detention center's website. On June 24, 2016 the auditor verified that the Annual Report to include aggregate data has been posted to their website. http://www.co.burlington.nj.us/1176/Juvenile-Detention-Center

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.



Auditor Signature

June 25, 2016

Date