PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: August 10, 2017

Auditor Information			
Auditor name: Susan Heck			
Address: PO Box 6032, Williamsburg, VA			
Email: susanheckva@gmail.com			
Telephone number: 757-784-1675			
Date of facility visit: July 27-28, 2017			
Facility Information			
Facility name: Henrico County Juvenile Detention Home			
Facility physical address: 4201 East Parham Road, Henrico, VA 23228			
Facility mailing address: *(if different from above)* P.O. Box 90775, Henrico, VA 23273-0775			
Facility telephone number: 804-501-4946			
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: Edward Martin			
Number of staff assigned to the facility in the last 12 months: 60			
Designed facility capacity: 20			
Current population of facility: Click here to enter text.			
Facility security levels/inmate custody levels: Orientation through Honor (detention facility/short term-short LOS)			
Age range of the population: 10-17			
Name of PREA Compliance Manager: Jerry Jackson		**Title:** Assistant Superintendent	
Email address: jac18@henrico.us		**Telephone number:** 804-501-4943	
Agency Information			
Name of agency: Henrico County			
Governing authority or parent agency: *(if applicable)* Henrico County			
Physical address: Click here to enter text.			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: Click here to enter text.			
Agency Chief Executive Officer			
Name: John A.Vithoulkas		**Title:** County Manager	
Email address: vit@henrico.us		**Telephone number:** 804-501-4943	
Agency-Wide PREA Coordinator			
Name: Jerry Jackson		**Title:** Assistant Superintendent	
Email address: jac18@henrico.us		**Telephone number:** 804-501-4943	

AUDIT FINDINGS

NARRATIVE

Henrico County Juvenile Detention Home (HJDH) is a secure detention facility for males and females from 10-17 serving the County of Henrico. Average length of stay is 6 days. The HJDH received an onsite PREA audit on July 27-28, 2017. A meeting was held on July 27, 2017 with the PREA Coordinator for the facility, Jerry Jackson, who provided the staff roster and a resident population roster.

The HJDH is a secure detention facility for youth aged 10-17 years of age which serves as a detention facility for court ordered Henrico County youth. HJDH was the county's first detention home and was built in 1979 with a maximum capacity of 20 youth. HJDH, along with neighboring jurisdictions, experienced a period of serious overcrowding, and the counties of Henrico, Powhatan and Goochland formed a commission to address this issue. Based on a needs assessment completed by the Virginia Department of Juvenile Justice, the counties formed a commission to oversee the building and future operation of an additional detention home in Powhatan County to serve all three jurisdictions. That facility, James River Detention Home, is HJDH's sister facility and is operated by a commission. Since James River Detention Home's completion, HJDH holds residents awaiting court, those with short lengths of stay and residents who are determined to need to stay at the facility throughout their confinement. Henrico County residents come to HJDH at the time of arrest and go through intake, await their initial court appearance and outcome, and then most go to James River Detention for the duration of their confinement if appropriate. Residents move back and forth from James River Detention Home to the HJDH for court hearings, doctor appointments, etc. In addition, residents who are medically fragile may stay at HJDH for the duration of their confinement due to its location and proximity to medical care. The average length of stay at HJDH is six days.

HJDH's philosophy is stated on its website and says, "The philosophy of the Henrico County Juvenile Detention Home is to hold in secure custody or on Detention Outreach and Electronic Monitoring those juveniles who, by statutory criteria, require such restraint for either their own or the community's protection. The objectives of the facility is to provide protection, safe care, basic needs and services as required by the Juveniles and Domestic Relations Court Law (Title 16.1 Code of Virginia) and pursuant to Standards for Secure Detention and Detention Outreach as approved by the State Department of Juvenile Justice and Interdepartmental Regulations." The facility provides educational opportunities for residents which are provided through Henrico County School Board. Residents are allowed to visit with parents and guardians and to meet with their attorneys.

The facility has a nurse on duty at the facility five days a week, and a doctor from VCU Health makes regular visits. In the event of a sexual assault, residents are transported to St. Mary's Hospital (part of the BonSecours Richmond Health System) which has a SAFE/SANE 24/7; an MOU with the hospital is in place and was reviewed by this auditor.

Mental health clinicians are provided five days a week through an agreement with Henrico Area Mental Health and Developmental Services. This mental health practitioner was interviewed and clearly acts as an integral part of the team at HJDH. An MOU covering this arrangement is in place and was reviewed by this auditor.

The facility's policy states that all allegations of sexual abuse are investigated; the facility has investigators to handle administrative and sexual harassment investigations. All four facility investigators have taken "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations" through NIC and certificates of completion were reviewed by this auditor. Three of the four investigators were interviewed during the on-site audit.

Any allegation that appears to be criminal in nature is referred to the Henrico County Police Department. Although there is not an MOU in place with the Henrico Police, there is an email from the Police Chief stating that they will do all the investigations, that the Henrico Police Department is the designated investigative agency, and that there is no need for an MOU. The facility's policy on ensuring investigations for all allegations of sexual abuse and sexual harassment is posted on its website.

There is an MOU with the Henrico County Department of Social Services that addresses its role and partnership with the police in investigating any allegations of sexual abuse at the facility and it was reviewed by this auditor. Calls were placed to both the after-hours hotline number and the local Child Protective Services unit. The hotline worker noted that he works three days a week and had never received a call from the facility other than two test calls (person from the facility doing unannounced rounds and testing the PREA phone).

Victim advocates for emotional support services related to sexual abuse are provided to residents 24/7 through calling the Victim Services Unit of the police department or by calling the YWCA of Richmond or Safe Harbor of Richmond. The executive director of Safe Harbor was contacted by this auditor and confirmed the relationship with the facility (the same relationship is in place for the community). Additional mental health services are provided through Bon Secours Richmond Health System. MOUs are in place with all these agencies and providers and were reviewed by this auditor.

Required PREA Auditor Notices were evident throughout the facility. Zero tolerance posters were also evident. Additional PREA posters have been added and are in both English and Spanish. The posters were varied to maintain resident interest, and a number of posters were made by residents. All residents knew about the zero-tolerance policy, knew how to report and to whom, and that they were protected

against retaliation. They were less knowledgeable about outside support services and this was discussed with the facility's PREA Coordinator.

This facility has a maximum of 20 residents and 60 total staff (including relief workers, administrators, etc.). The resident population was twelve on the first day of the audit. All twelve residents were interviewed; one resident was reluctant but did answer several questions and stated that the "facility has this PREA thing; they're on it". All twelve residents' files were reviewed for vulnerability assessments and PREA education and all were in compliance with the standard.

Of the 60 total staff, 10 secure staff interviews (of 17 direct care/counselors available) were completed and 13 specialty interviews were completed (including investigators, staff monitoring retaliation, HR staff, superintendent, medical and mental health staff, PREA Coordinator/PREA Compliance Manager, administrators conducting unannounced rounds, members of incident review team). In addition, five intake staff interviews were completed and five interviews with staff who administer vulnerability assessment were completed. Staff in this facility are cross-trained in several areas, so interviews were conducted with staff members who conduct vulnerability assessments and PREA education from each shift, including the midnight to 7:00 am shift. This is a small facility, and staff members often perform multiple duties. Note that some staff took part in more than one interview (some staff were interviewed as a secure staff, staff who did intake and education, and staff who conducted vulnerability assessments, for instance). This was necessary to cover the different aspects of the PREA standards represented in the interview formats. In total, 33 staff interviews and 12 resident interviews were conducted over the course of the on-site audit, representing just over half of the staff and all residents in population.

The facility's current staffing ratio is 1:8 during waking hours and 1:16 during sleeping hours which meets the standard (which has an implementation date of 2017). The facility adds additional staff based on the population; extra staff are called in when the population includes residents who have negative relationships with each other in the community or if the composition of residents in population call for extra attention or supervision. The superintendent noted that they sometimes have youth with significant mental health concerns that require one to one supervision, and the facility calls in additional staff. He stated that they talk about staffing on an ongoing basis and adjust to ensure the safety of the residents. The facility's staffing plan makes use of a form to document both its review and to ensure all elements covered in the standard are considered during the review. The most current review of the staffing plan was provided to this auditor.

Education of residents is provided through Henrico Public Schools, Special Education Department, and is provided on site. School was not in session at the time of this audit, so no teachers or administrators for the school system were on site.

The showers in this facility are designed with two shower stalls side by side. They are separate from each other. Residents are sent to the showers two at a time with each resident showering in a separate stall. Staff supervise from the hallway and have a clear view of the entrance to the shower stalls; during the facility tour they demonstrated to this auditor where they position themselves to ensure residents do not move from one shower stall to the other while keeping the residents from being viewed by the staff while they shower. Residents who are determined to be vulnerable are showered one at a time, either first or last. Residents are allowed to bathe, shower, toilet without being viewed by the opposite gender.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility was toured by this auditor on July 27, 2017; the PREA Coordinator, Jerry Jackson, conducted the tour. All areas of the facility were made available to this auditor.

The facility is a one-story brick structure, rectangular in shape, with a large outdoor recreation yard in the back. It was built in 1979. The building and outdoor recreation area in the back are surrounded by a fence on three sides. The front entrance faces a parking lot. The front entrance of the facility opens into a lobby which has secure doors leading to the administrative part of the building or through to the part of the building that houses residents. The administrative area is located through the door on the right-hand side of the lobby. The administrative area includes a reception area, cubicles and the offices of the superintendent, assistant superintendents and other administrative staff.

There is a short hallway (behind the lobby) that leads from the administrative offices to the kitchen area (this door is secured; entrance is controlled by a wall box with a code or the control room). The kitchen is a large rectangular area with a storage room at the end. There is a roll up aluminum window that opens during mealtime for residents to receive their food. Residents are not allowed into the kitchen area at any time. (Any resident or staff going into the kitchen would pass the control room; there is a camera that covers the kitchen hallway). A door to the right (also secured by a wall box or the control room) just before the kitchen area door leads into a very small vestibule and another secured door which leads to the main part of the building used by staff and residents.

This part of the building is centered around a very large, open multi-purpose/recreation area (roughly the size of half a basketball court). Two story height ceiling windows make the space very light. Surrounding this area are the control room, dining room with access to laundry room (secured door; only staff do laundry), an intake office, medical office, video conferencing room, the classroom and both housing units. A door along the back wall opens to the outside recreation area which has a basketball court and large grassy areas. All the rooms/areas which surround the multi-purpose room have windows or doors with glass openings, making the line of sight excellent throughout this space.

There are two housing units, one on each side of the large multi-purpose room, the boys side and the girls side. Each has a large quiet room with a door to a hallway where the single-occupancy sleeping rooms and a shower area are located. There are 12 single-occupancy rooms on the boys' side and 8 single-occupancy rooms on the girls' side. Two of the rooms on each side are separated from the other sleeping rooms by an additional secured door. The facility uses these rooms to help with population management. If there are more than twelve male residents and the male housing unit is full, two additional males can be housed on the other side in these rooms that are separated from the other rooms. The same is true if there were more than eight female residents. Each sleeping room has a small window in the door to allow for supervision of youth. The quiet room has couches, chairs, tables, a television, and a staff desk area. There is a bulletin board with information readily accessible to residents. PREA information, including the Notice of Audit, were visible on both housing units. The quiet room is rectangular in shape with windows in the wall facing the multi-purpose room area. There is a door to the sleeping room areas which also has a glass window.

The shower area on each of the housing units contains two shower stalls side by side. Two residents shower at a time, each in a separate shower stall. Staff supervise from the hallway and demonstrated where they position themselves to ensure residents do not move from one shower staff to the other yet keep the residents from being viewed by the staff while they shower. There are no cameras in the shower area itself. The hallway has camera coverage.

There is a hallway on the right of the open rec area between the Girls' Quiet room and the classroom leading to the facility's medical unit and a conference/training room area. This part of the building was added in 2011 and includes space for the medical unit and a conference room, and also bridges the Detention Home with the Juvenile Court building. The medical unit, including an office area for the doctor and nurse, waiting room and exam rooms, and a staff conference room are located in this area. The medical area is open; the waiting room is covered with a camera but no cameras are in the exam rooms. Additional PREA posters have been added to the waiting room of the medical area since the facility's last audit. The door which connects the Detention Home to the juvenile court is a secure door at the end of the hallway just after the entrance to the medical area.

Cameras and video monitoring are well positioned throughout the building, also covering the outside recreation area, the sally port area and the front of the facility. There are 27 total cameras, 20 inside the facility and seven covering the outside. Six of these cameras were purchased since 2012 and their placement was carefully planned to cover blind spots in the facility. One interior camera was added in 2014 and three exterior cameras and two interior cameras were added this year. This auditor noted the placements of cameras on the blueprint of the facility provided at the time of the audit; no blind spots were noted by this auditor. Cameras may be viewed from the desks of administrators, the nurse's desk and from the control room. No cameras were positioned in ways that interfered with residents' privacy during changing, bathing, toileting activities.

Storage areas in the facility were locked as appropriate. The facility was built with many internal windows, making the line of sight in the building very good for constant monitoring of residents and staff. The resident phone is located on the wall outside the Girls' Quiet Room and is clearly labeled "PREA Phone". There are additional "zero-tolerance" posters in this area. This phone connects with local Department of Social Services, Child Protective Services during the day and to the state hotline after 4:00 pm. Another phone for resident

use is inside the Video Conferencing room and important numbers are posted next to it.

SUMMARY OF AUDIT FINDINGS

The on-site audit of Henrico Juvenile Detention Home (HJDH) was completed on July 28, 2017.

Compliance with the PREA standards and a true commitment to keep residents in their care safe and free from sexual abuse and sexual harassment is evident at HJDH. Although not specifically addressed in the PREA standards, the facilty's staff retention rates are excellent and seem to point to the strength of its leadership team. The facility's longtime superintendent retired (and subsequently passed away) within the past year. It is a credit to the new superintendent (promoted from the position of assistant superintendent) that the facility's staff continues to have a high regard for its administrative team and the facility continues to demonstrate a healthy culture and environment.

Sincere thanks to Jerry Jackson, Assistant Superintendent (and PREA Coordinator/PREA Compliance Manager) for his help throughout the audit process, both before the audit in sending documents on time and during the onsite audit process.

Number of standards exceeded: 2

Number of standards met: 38

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.

Evidence:
HJDH Policy 6.1, I -Prevention Planning, II-Policy, pp. 1-4
Organizational Chart
Interview with PREA Coordinator (both PREA Coordinator and PREA Compliance Manager interviews conducted)

Policy is thorough and covers all elements of the standard. Very good description of prohibited actions (specifically addresses correspondence or conversations with residents that are romantic in nature as a prohibited actions) and methods to prevent and detect. Policy clarifies that residents may not consent-- addresses claims of consent by residents. Policy includes references to federal law.

This facility is a stand-alone facility and has a PREA Coordinator. The organizational chart was submitted and reviewed. The organizational chart identifies the Assistant Superintendent of Operations as the PREA Coordinator. Both PREA Coordinator and PREA Compliance Manager interviews were conducted with Jerry Johnson, PREA Coordinator for Henrico Juvenile Detention Home. He is committed to his role as PREA Coordinator and the importance of preventing, detecting and responding to any incidents of sexual abuse and sexual harassment. He is very knowledgeable about the standards and stated that he has sufficient time to devote to his PREA Coordinator duties. He views PREA compliance as an ongoing effort and discussed "next steps" and ways to continue to improve the facility's efforts with this auditor during the time of the audit.

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.

Evidence:
HJDH Policy 6.1, Contracting with other entities for the confinement of residents, pg. 4.

This facility does not contract with other entities for the confinement of residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
HJDH PREA Policy 6.1, Supervision and Monitoring, pg. 5-6
Interview with Superintendent
Interview with administrative staff who conduct unannounced rounds
Review of Unannounced Rounds log
Review of facility's yearly review of the staffing plan

All elements of the standard are considered in the facility policy. Interview with the superintendent corroborated adherence to the staffing plan which is at 1:8 (ahead of the deadline to meet this staffing ratio for waking hours) and 1:10 for resident sleeping hours which exceeds the PREA standard. (State regulations remain at 1:10 for waking hours.) Staffing plan is based on the facility's capacity of 20 residents; the average daily number of residents since the last audit is thirteen. Superintendent stated that they call in extra staff depending not only on the number of youth in the facility, but also on the makeup of that population; he noted that they sometimes have residents who require one-to-one supervision for various reasons (such as mental health issues or physically aggressive youth). There have been no incidents of not meeting the staffing plan in the past twelve months.

Documentation of the facility's formal staffing plan review was provided and reviewed. The superintendent noted the facility's staffing plan is reviewed in monthly staff meetings and in daily shift meetings to ensure proper coverage. The facility uses a form entitled "HJDH PREA Staffing/Facility Logistics Assessment" to ensure all elements of the standard are considered during staffing review.

Two administrators who conduct unannounced rounds were interviewed. This facility believes in "management by walking around", so it is not unusual to see administrators in the housing units or interacting with residents and staff; staff would not be able to distinguish a PREA round other than an unannounced round that happens in the middle of the night absent an emergency. Staff are not notified of PREA rounds. Rounds are conducted one time a month on all shifts. Logs of the rounds were reviewed and included notations when the PREA "hotline" was checked during rounds. (These calls were confirmed by the hotline worker interviewed who noted that he had received two "practice" calls from the facility.) This auditor's suggestion from the facility's last PREA audit to keep these rounds separate has been incorporated into their practice. Rounds noted "no PREA incident", and the form includes language to prompt staff doing the rounds of its purpose and goal.

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.

Evidence:
HJDH PREA Policy 6.1, Limits to Cross-gender viewing and searches
Interviews with secure staff
Interviews with residents

Interview with medical staff

Policy mirrors standard. Policy includes a general definition section which defines "exigent", "gender nonconforming", "intersex", and "transgender". Staff indicated that they do not do cross-gender searches and they do not do cross-gender strip searches or cross-gender visual body cavity searches. All residents interviewed confirmed that the facility does not do cross-gender searches. Medical staff indicated that a body cavity search would be done at the hospital. There have been no incidents of cross-gender searches done at this facility in the past 12 months. There have been no incidents of cross-gender strip or body cavity searches at this facility in the past 12 months.

There were no transgender or intersex residents in the current population at the time of the audit. Facility used the Cross-Gender Search training available on the PRC to train all staff and provided training rosters that were reviewed by this auditor. This training has been incorporated into the facility's annual training for staff in addition to being part of training for new hires. In addition, all staff knew that searching a transgender or intersex resident to determine that resident's genital status was prohibited.

Staff indicated that they announce their presence (most noted that female staff rarely go into the male living unit). All administrators of this facility are male. Resident interviews confirmed adherence to this standard.

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.

HJDH PREA Policy 6.1, Residents with disabilities & limited English proficient residents, pg. 8
Review of Henrico County Employee and Citizen Language Bank
Interview with Agency Head designee
Interviews with residents
Interviews with secure staff
Review of resident brochure in Spanish

Facility has the use of Henrico County Employee and Citizen Language Bank for residents who are non-English speaking. Resident brochure is available in Spanish (the most often non-English language represented) and PREA posters in Spanish are posted throughout the facility. Staff interviews confirm that residents do not translate for other residents. There were no residents who were not English proficient or disabled in population at the time of the audit. Superintendent stated that they use the Henrico County language bank noted in "Evidence" above or ask for assistance (during regular business hours) from a staff member in the Henrico County JDR Clerk's Office who speaks/reads/writes Spanish fluently. The language bank is available 24/7 to all citizens and agencies in the county.

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.

Evidence:
HJDH PREA Policy 6.1, Hiring and promotion decisions, pg. 9
Review of Henrico County HR policy
Interview with HR hiring manager at facility
Review of "HJDH PREA Questionnaire for Fitness to Hire, Promote or Continue Contract"
Review of facility personnel files (reviewed files of all staff interviewed during on-site audit)

The facility's policy is consistent with all elements of the standard. All required background checks are conducted; files of all employees interviewed were reviewed and all contained the necessary original checks and subsequent five-year checks as indicated. The facility uses its "HJDH PREA Questionnaire for Fitness to Hire, Promote or Continue Contract" form to ensure compliance with all parts of the standard. The form is used for new hires and promotions and is also signed by all staff during yearly training (form includes reminder of continuing duty to report). All staff had recently signed the form; these forms were reviewed by this auditor.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
HJDH PREA Policy 6.1, Upgrades to facilities and technologies, pg. 9
Interview with PREA coordinator
Interview with superintendent

Policy mirrors standard. In addition, policy does an excellent job of describing what any modifications to the facility or any additional cameras added to the current system should be considering. Policy provides additional guidance for staff in terms of lines of sight in the facility and how staff should position themselves in rooms without clear lines of sight (two staff, one the same gender as the resident being supervised).

No cameras have been added since the date of the last PREA audit and no additions or modifications have been made to the facility since the time of the last audit.

This standard is N/A for this facility for this audit.

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.

Evidence:
HJDH PREA Policy, Evidence protocol and forensic medical examinations, pg. 10
Interviews with staff
Interview with PREA Coordinator
Interview with medical personnel
MOU with Henrico County Department of Social Services
MOUs with Bon Secours Richmond Health System (St. Mary's Hospital); YWCA of Richmond and Safe Harbor in Richmond
Email from Henrico County Police Department (legal authority to conduct criminal investigations)

The facility conducts administrative sexual abuse investigations and sexual harassment investigations only. Any allegation that appears to be criminal in nature is referred to the Henrico County Police or Henrico County Sheriff's Department and the Henrico County Department of Social Services (CPS) for investigation. Facility requested MOU from HCPD, however, HCPD did not feel an MOU was required since they are the legal authority to investigate such allegations. This auditor reviewed email from Assistant Chief of Police stating same. The policy states the facility will ask the HCPD to use a developmentally appropriate protocol to ensure compliance with the standard. The HCPD is aware of PREA standards and requirements and its responsibility to adhere to such standards.

Facility policy states that any resident who experiences sexual abuse will be offered access to forensic exams at St. Mary's Hospital which has SAFE/SANE staff available 24/7. There will be no financial cost to the resident. Medical staff corroborated that any forensic exam would be conducted at St. Mary's Hospital with SAFE/SANE staff. Interviews with direct care staff indicated that they understood their duty to preserve evidence and how to do it. There have been no allegations of sexual abuse in the past 12 months.

Facility has MOUs in place with Bon Secours Richmond Health System (St. Mary's Hospital); YWCA of Richmond and Safe Harbor in Richmond to provide victim advocates as referenced in (d) and (e) of the standard. St. Mary's Hospital would conduct any forensic exams and works closely with YWCA/Safe Harbor of Richmond to provide advocates for victims of sexual assault. MOU with them indicates that they will provide this service to any resident sexual abuse victims at HJDH.

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.

Evidence:
HJDH PREA Policy 6.1, Policies to ensure referrals of allegations for investigations; #1, pg. 10
Interview with facility investigator
MOU with Henrico County Department of Social Services
Email from Henrico County Police Department
Review of website for published policy on referrals of allegations

Facility policy mirrors standard. HJDH will ensure allegations of sexual abuse which may be criminal in nature are referred to Henrico Police Department or Henrico Sherriff's Department, agencies with the legal authority to conduct criminal investigations. The facility

publishes its policy ensuring that allegations of sexual abuse or sexual harassment are referred for investigation (or investigated internally) on its website. Policy clearly delineates the responsibilities of the facility and the HCPD or Sheriff's Department. There have been no allegations of sexual abuse. Three of the facility's four investigators were interviewed and indicated that any investigation that appeared to be criminal in nature would be referred to police.

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.

Evidence:
HJDH PREA Policy 6.1, V. Training and Education, Employee Training, pg. 11-12
Training records of all staff interviewed were reviewed
Certificates reviewed
Interviews with secure staff

Facility policy mirrors standard and training for employees includes all elements listed in the standard. Each employee signs that they received and understand the training. In addition to new employee orientation by a member of the HJDH staff, the facility has made excellent use of the on-line resources available on the PRC. All staff have seen: "PREA: Your Role Responding to Sexual Abuse", "Respectful Communication with LGBTI Residents", training on first responder responsibilities and training on conducting Cross-Gender Pat Down searches.

This auditor reviewed training records of all staff selected for interviews. All indicated they had received the training, and a review of their training records confirmed. Staff sign their training rosters, confirming they have attended the training and that they understand the training they received.

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.

Evidence:
HJDH PREA Policy 6.1, V. Training and Education, Employee Training, pg. 11-12
Prison Rape Elimination Act (PREA Acknowledgement Statement
Review of training record
Interview with contractor

Facility policy mirrors standard. Volunteers and contractors are trained on zero-tolerance policy; how to report sexual abuse; and their roles in helping to detect, prevent and respond to sexual abuse and sexual harassment. The training they receive is based on the services they provide. Facility documents that volunteers and contractors understand the training they receive with signatures on the "Prison Rape Elimination Act (PREA Acknowledgement Statement". The facility does not currently have any volunteers who have contact with residents; this auditor reviewed the training record for the facility's contractor (provides mental health services).

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.

Evidence:
HJDH PREA Policy 6.1, V. Training and Education, Resident Education, pg. 12-13
Reviewed Resident Handbook
Reviewed "How to Report Sexual Abuse" brochure, Spanish version available
Interviewed Intake Staff
Interviewed residents
Reviewed "Prison Rape Elimination Act (PREA) Acknowledgement Statement"

The average length of stay at this facility is six days. Of the 633 new intake admissions over the past 12 months, all received PREA education during intake on their first day. Since the time of the last PREA audit the facility has been doing PREA education at intake, and has moved to having 100% of residents receiving the information within the timeframes required by the standards. Interviews with staff who do resident intake and with residents confirmed this practice.

This facility has a unique relationship with its sister facility, James River Detention Home. Residents from Henrico County come into intake at HJDH and all are provided PREA Education and are screened for vulnerability on the first day. New intakes to HJDH who receive longer lengths of stay (or possible assignment to a Post-D Program) are transferred to James River Detention to serve out their times of confinement as determined by the juvenile court. If those residents come back to court or need to see a doctor for a special appointment or follow-up, they are sent back to HJDH the day before court/appointment. Those residents are not considered "new" intakes since they have already been through their intakes and will be going back to James River (unless they are released). Any transfer to HJDH from a facility *other than James River* is considered a "new" intake for HJDH and receives the education and vulnerability screening all intakes that come from court or the community and are new to HJDH receive. In addition, if a resident is *released* and comes back to HJDH after re-offending, he/she is considered a new intake and receives PREA education and vulnerability screening as though he/she has never been to the facility.

This auditor reviewed the resident handbook, PREA brochure and Resident Orientation sheet which residents sign indicating they have received the information and understand it. Information is made available to residents who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as those who have low reading skills.

Posters are in the dining hall, intake area, around the PREA telephone, in housing units and throughout the facility. PREA posters have been added in the medical area's waiting room as suggested at the time of the last audit. The facility has engaged the residents in this process and resident designed posters are also throughout 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)

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.

Evidence:
HJDH PREA Policy 6.1, V. Training and Education, Specialized Training: Investigations, pg. 13
Reviewed Certificates of Completion, "PREA: Investigating Sexual Abuse in a Confinement Setting"
Reviewed Certificates of Completion, "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations"
Interviews with investigators

Four staff are designated as facility investigators and would investigate sexual harassment and administrative sexual abuse allegations. All four have taken "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations" trainings available through NIC. Certificates of Completion were available and reviewed. Three of four staff who are tasked with doing investigations in addition to their regular duties were interviewed and indicate understanding of the training they received. Note: this facility refers all allegations of sexual abuse which may be criminal to Henrico County Police Department or Henrico Sherriff's Department for investigation.

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.

Evidence:
HJDH PREA Policy 6.1, V. Training and Education, Specialized Training: Medical and Mental Health Care, pg. 13-14
Certificate of training from "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting"
Interview with medical personnel
Interview with mental health practitioner

Facility policy mirrors standard. Medical personnel have all taken PREA training for employees in addition to the required specialized training required by the standard and the required training is documented. Certificates of completion for training were reviewed. Forensic exams are not conducted at the facility; residents are transported to St. Mary's Hospital. Interview with medical personnel confirm understanding of the training they have received and confirmed that forensic exams would be conducted at St. Mary's Hospital, not at the facility.

Mental health care practitioner has received training on PREA for employees in addition to taking specialized training for mental health staff provided on-line. Documentation of PREA training and certificate of specialized training were provided and reviewed.

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.

Evidence:
HJDH PREA Policy 6.1, VI. Screening for risk of sexual Victimization and abusiveness; Obtaining information from residents, pg. 14-15
Review of Juvenile Detention Assessment form
Interviews with residents
Interviews with staff who administer Vulnerability Assessment tool
Interview with PREA Coordinator/PREA compliance manager
Review of resident files to document administration of assessment using objective screening tool within required timeframe

All elements in the standard are included in the facility's screening instrument in addition to others. Facility policy incorporates all elements of the standard. There are prompts within the assessment to ask the resident directly (re perception of vulnerability). Since this is an intake facility, additional records are often unavailable. All staff interviewed noted that they use court records when available and talked with parents when possible. All indicated that they ask questions of residents directly and resident interviews confirmed this.

This facility is primarily an intake facility with an average length of stay of six days. The risk assessment information is gathered and used during placement, but the size of the facility and the short LOS combine to limit the assessments usability in terms of placing residents in living units (there is only one male and one female living unit).

Appropriate controls have been put in place to protect the resident's information. Policy references the facility's Confidentiality Policy and Policy Record Organization and Management to ensure information is treated confidentially.

This is a small facility that does not have a designated "intake" unit. Multiple staff do both intake education and vulnerability screenings. Interviews were conducted with staff members on all shifts who conduct screenings and all were comfortable with doing the assessments and the role the assessment had in making housing assignments (this facility has only two housing units, one male and one female, so there are limited choices).

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.

Evidence:
HJDH PREA Policy 6.1, VI. Screening for risk of sexual Victimization and abusiveness; HJDH Resident Placement, pg. 15-16
Review of HJDH Policy Resident Rules and Discipline; Behavior Management Program
Review of HJDH Disciplinary Process for Minor and Major Infractions

Interviews with staff who conduct risk screening
Interview with mental health staff
Interview with superintendent
Interview with PREA coordinator/PREA compliance manager

PREA Coordinator stated that housing for transgender or intersex resident would be determined on a case by case basis considering other population and the resident's self-identity and stated that the resident's own views with respect to safety would be considered. No transgender or intersex residents were part of the population at the time of the on-site audit. Policy states that isolation is used for discipline purposes when other interventions haven't been effective. Residents are not isolated based on information obtained in risk screening. Zero residents have been placed in isolation because they were at risk of sexual abuse or of abusing others. The facility policy addresses all elements of the standard.

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.

Evidence:
HJDH PREA Policy 6.1, VII. Reporting, Resident Reporting, pg. 16-17
Resident handbook
Resident brochure "How to Report Sexual Abuse"
Resident interviews
Staff interviews
Interview with PREA coordinator

Information on how to report is in the resident handbook and in the, "How to Report Sexual Abuse" brochure. Residents are provided with tools necessary to make a report in writing or by being given access to the phone. All staff indicated that verbal reports are accepted and documented immediately. Interviews with staff, residents and PREA Coordinator indicate that residents have multiple ways to report, including reporting outside the facility. Policy covers all elements of the standard and incorporates the numbers and contact information for reporting in the policy. While residents are allowed to use the tools available for writing a grievance (forms and writing instruments), they are told that any allegation of sexual abuse or sexual harassment is referred to investigators in the facility and on to the police if the allegation appears to be criminal in nature. This information is reiterated in the Resident Handbook (Grievance Procedure on the back page), on forms available to residents for making written allegations. Residents are very familiar with using the form to report their needs or anything unfair, so the facility has allowed them to continue using it while educating them on the different process used for handling sexual abuse or sexual harassment allegations. The revised forms ensure residents are aware that this type of allegation is NOT handled with the grievance process. All allegations are referred to facility investigators or to police/sheriff's department (with the legal authority to investigate criminal allegations).

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.

Evidence:
PREA Policy 6.1, VII. Reporting, Exhaustion of Administrative Remedies, pg. 17-18
"How to Report Sexual Abuse" brochure
Grievance Procedure, 6 VAC 35-101-100
Resident Handbook
Resident interviews

The facility allows residents to use a grievance form to make a written allegation of sexual abuse or sexual harassment because this is a tool that residents are familiar with and know how to use. The facility has modified the procedure to ensure that residents know that any and all allegations of sexual abuse or sexual harassment are immediately referred to the facility's specially trained investigators and possibly to Henrico PD or Henrico Sherriff's Department (the agencies with the legal authority to investigate allegations that appear to be criminal in nature). There have been no written grievance forms alleging sexual abuse. The Resident Handbook has the grievance procedure on the back and clearly states the process for investigating written allegations of sexual abuse or any sexual harassment and that they are handled outside the normal process for grievances. The "How to Report Sexual Abuse" brochure also tells residents they may use the grievance form and describes how such an allegation will be handled. The updated grievance procedure is posted in the living units, multipurpose room and lobby. It is accessible to residents and parents/legal guardians.

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.

Evidence:
PREA Policy 6.1, VII. Reporting, Resident access to outside support services and legal representation, pg. 19
Interviews residents
Interview with superintendent
Interview with PREA compliance manager
MOU with Safe Harbor reviewed
MOU with YWCA reviewed
MOU with Bon Secours reviewed
"How to Report Sexual Abuse" brochure reviewed

Of the 12 residents interviewed nine knew that outside support services were available to them, one of these was unsure what they were, just knew they existed. Three residents did not know they existed. Auditor suggested to the facility's PREA Coordinator during de-brief that this is an area to provide more information or post information in more places. He stated that he would ask the nursing staff to add a class on this to their "in-service" topics with residents. Residents were also not clear on limits of confidentiality; only four of the residents understood the concept of mandated reporting and what that meant from community providers' perspective. The facility has MOUs with outside support services including DSS/CPS, YWCA, Safe Harbor in place to provide confidential emotional support services. This auditor talked with representatives from Child Protective Services and Safe Harbor to confirm these relationships and support service provision.

Residents indicated they could see their attorneys privately. Residents indicated that they could see parents during visitation but only in large room used for everyone's visitation. Residents said the facility spreads the tables apart, but noted they were in a room with everyone else.

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.

Evidence:
HJDH PREA Policy 6.1 Third-party reporting, pg. 20
Review of facility website

Information on how to make reports is available on the facility's website. Information is available at the facility in pamphlets and on posters throughout the facility.

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.

Evidence:
HJDH PREA Policy 6.1, VIII. Official Response Following a Resident Report, Staff and agency reporting duties, pg. 20
Interviews with staff
Interview with medical staff
Interview with PREA Coordinator/PREA Compliance Manager
Interview with superintendent

Staff knew of their duty to report any incidence of sexual abuse, any knowledge of sexual abuse and any staff neglect that contributed to an incident of any kind. They knew how to report within the facility's chain of command and that they could report outside the facility. Nurse stated that she knew of her duty to report; she has not received an allegation of this type. No allegations of sexual abuse from this facility. PREA Coordinator and superintendent both knew their responsibility to report to parents, DSS, and the juvenile court. This facility has not had an allegation of sexual abuse.

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.

Evidence:
HJDH PREA Policy 6.1, VIII. Official Response Following a Resident Report, Agency Protection Duties, pg. 21
Staff interviews
Superintendent interview

Agency has not received a report that a resident was subject to substantial risk of imminent sexual abuse. Policy mirrors standard. All staff interviewed were aware of their duty to respond and to protect the resident immediately. Superintendent noted that they would move to protect the resident through any means available including one-to-one supervision, showering first or last, etc. He noted that his expectation is that staff would respond immediately.

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.

Evidence:
HJDH PREA Policy 6.1, VIII. Official Response Following a Resident Report, Reporting to other confinement facilities, pg. 21
Superintendent interview

The policy mirrors the standard. Superintendent stated that the report from the other facility would be investigated as thoroughly as it would be if the resident had reported it while at HJDH. They have not gotten a report from another facility (nor have they gotten a report from a resident that something happened to him/her at another facility).

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.

Evidence:
HJDH PREA Policy 6.1, VIII. Official Response Following a Resident Report, Staff First Responder Duties, pg. 22
Staff interviews

Policy mirrors the standard and has all elements. There have been no allegations of sexual abuse at this facility in the past 12 months. All staff interviewed knew what they were required to do as first responders and listed the steps; most interviewed staff listed protection of alleged victim as the first step.

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.

Evidence:
PREA Policy 6.1, VIII. Official Response Following a Resident Report, Coordinated response, pg. 23;
PREA Policy 6.1, XII Data Collection and Review, Sexual Violence Incident Reviews, pg. 32
Interview with superintendent

The facility's policy thoroughly describes the purpose of a coordinated response, the structure and purpose of its SART Team, the necessary steps in responding to an incident of sexual abuse and who would be responsible for which parts. Policy incorporates Data Collection and Review, and Sexual Violence Incident Reviews into meeting compliance with this standard. The superintendent stated that the coordinated plan was understood by his administrative team and staff and sufficient to ensure the safety of residents. This auditor suggested that the plan be posted in an area available to staff on the two housing units to ensure staff had access in event of an incident of sexual abuse.

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.

Evidence:

PREA Policy .1 Preservation of ability to protect residents from contact with abusers
Interview with superintendent

This standard does not apply in Virginia. See the Commonwealth of Virginia CODE 40.1-57.2 Prohibition against collective bargaining.

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.

Evidence:
HJDH PREA Policy 6.1, VIII. Official Response Following a Resident Report, Agency protection against retaliation, pg. 24
Interview with superintendent
Interview with agency head
Interview with staff tasked with monitoring retaliation against staff or residents.

This facility has had no allegations of sexual abuse and therefore has not needed to monitor retaliation against staff. The facility's PREA policy clearly defines the responsibility for monitoring for retaliation should an allegation be made. The facility has developed an excellent tool to monitor and track its efforts to monitor retaliation should it be necessary. The form incorporates all elements included in the standard. Facility policy states that monitoring will continue for 120 days which substantially exceeds the standard requirement. Interview with staff who monitors retaliation indicates thorough understanding of steps necessary and their importance; he takes this role very seriously.

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.

Evidence:
HJDH PREA Policy 6.1 Post-Allegation protective custody, pg. 25.
Interview with medical staff
Interview with superintendent

There have been no allegations of sexual abuse in this facility for the past 12 months. Interviews with medical staff and superintendent indicate understanding of responsibilities if a resident is in isolation after an allegation; there have been no allegations and no isolation used after an allegation to protect a resident. Policy references protections listed under "HJDH Resident Placement" which ensures that any resident in isolation receives large muscle exercise, access to education and programming and visits from mental health and medical staff,

and meets requirements of the standard. Policy notes that well-being of alleged victim will be the primary focus in these decisions.

Policy further instructs that the alleged victim will not be housed in the same area as the alleged perpetrator; staff will be removed from contact with alleged victim, and emotional support services for residents or staff who fear retaliation will be implemented, documented and monitored.

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.

Evidence:
PREA Policy 6.1, IX Investigations, Criminal and administrative agency investigations, pg. 26
Review of training certificates of facility investigators
Review of MOU with DSS/CPS
Interviews with investigators (three of four interviewed)
Interview with PREA Coordinator
Interview with superintendent
Review of email from Assistant Chief of Police

Facility's policy incorporates elements of the standard. Facility investigators conduct administrative investigations only. Facility refers potentially criminal matters to Henrico Sheriff's Department or Henrico PD and to CPS. Police email indicates that they do not feel an MOU is necessary since they are the presumed responder. An MOU is on file with DSS/CPS. All four facility investigators have taken "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations" trainings available through NIC. Certificates of Completion were available and reviewed.

Three of four facility investigators interviewed; interviews indicated knowledge of procedures and process.

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.

Evidence:
PREA Policy 6.1 Evidentiary Standard for administrative investigations, pg. 26
Interviews with three of four facility investigators

Reviewed certificates for all investigators "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations"

Three of four facility investigators were interviewed and indicated preponderance of evidence as the standard of evidence for administrative investigations. All four have taken "PREA: Investigating Sexual Abuse in a Confinement Setting" and "Investigating Sexual Abuse in a Confinement Setting Advanced Investigations" trainings available through NIC. Certificates of Completion for both courses for all four facility investigators were available and reviewed. This facility has had no allegations of sexual abuse.

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.

Evidence:
HJDH PREA Policy 6.1, IX Investigations, Reporting to residents, pg. 26-27
Interview with superintendent
Interview with investigators (three of four investigators interviewed)

The facility's policy mirrors the standard. There have been no allegations/no investigations/no reports. (Note that the average length of stay at this facility is six days.) The facility conducts administrative investigations only. Facility will request information about the investigation from the investigative entity to inform resident to be in compliance with the standard. Interview with superintendent indicated knowledge of proper procedure and process. No residents have made allegations so no residents to interview. Interviews with three of four facility investigators indicated their understanding of the requirement to report 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.

Evidence:
HJDH PREA Policy 6.1, X. Discipline, Disciplinary sanctions for staff, pg. 27

The facility's policy mirrors the standard. Facility policy also references Henrico County personnel policy re disciplinary sanctions. There have been no allegations against staff. No staff have been disciplined; there were no files to review. All documentation reviewed made it clear that staff would be subject to discipline up to and including termination for any infraction under its Zero Tolerance Policy.

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.

Evidence:
HJDH PREA Policy 6.1, X. Discipline, Corrective action for contractors and volunteers, pg. 27
Interview with superintendent

Policy mirrors the standard. Policy further states that facility has both the authority and responsibility to deny any volunteer, intern or contractor access to the facility if it is believed to jeopardize the order, security or safety of the residents. There have been no reports against contractors or volunteers. Superintendent indicated that any volunteer or contractor who violated the agency's zero tolerance policy would be denied future access to the facility. He also stated that reports would be made to proper authorities.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 6.1, X. Interventions and Disciplinary Sanctions for residents, pg. 28
Interview with superintendent
Interview with mental health staff
Review of HJDH Policy Resident Rules and Discipline: Behavior Management Program

Facility policy mirrors standard. There have been no allegations against a resident. All sexual contact between residents is prohibited by the facility. Residents may not be disciplined for sexual contact with staff unless staff did not consent to such contact. Any ongoing mental health treatment is referred to community provider. Superintendent indicated that the mental health of the perpetrator would be considered. Facility policy indicates that it would refer all allegations for investigation and criminal charges are possible if allegation is determined to be substantiated.

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.

Evidence:
HJDH PREA Policy 6.1, XI. Medical and Medical Care, Medical and mental health screenings history of sexual abuse, pg. 30
Interview with staff who do risk assessments
Interview with mental health staff

Policy mirrors standard with additional information on documents to be reviewed during ongoing, periodic reviews. Facility policy requires follow-up meeting with medical/mental health provider within 72 hours for residents who indicate prior sexual abuse or having previously perpetrated sexual abuse.

A query was executed using the facility's "Soft-Tec" electronic case management system to identify residents who were at the facility over the last year for 14 days or longer. Fifty-four residents were in this list and all of their files were reviewed. Of the 54 residents, thirteen screened as vulnerable based on prior sexual abuse victimization; no residents answered yes to having been prior perpetrators of sexual abuse. Of the thirteen residents, twelve got follow-up meetings with a mental health/medical provider. Note that policy states this meeting should happen within 72 hours; policy provides additional references to documents which may be used to secure information.

Interview with mental health staff indicated knowledge of referral process and understanding of the standard. She stated that staff who do the assessment refer residents for any vulnerability, not just prior sexual abuse or prior perpetrators of sexual abuse. Residents needing in-depth treatment would be referred outside.

The facility made an adjustment to the Soft-Tec system during the on-site PREA audit to further ensure that the follow-up meetings are offered to residents. An additional prompt was placed next to the question about prior victimization/prior abusiveness that will allow the staff conducting the risk assessment to check the box and have the referral go to the mental health practitioner immediately through the electronic prompt.

The facility does obtain informed consent as part of its intake medical/mental health screening.

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.

Evidence:
HJDH PREA Policy 6.1, XI. Medical and Medical Care, Access to emergency medical and mental health services, pg. 30-31
Interview with nurse
Interview with secure staff

Facility policy mirrors standard. Interview with nurse demonstrated knowledge of the process; residents would be transported to St. Mary's Hospital for treatment; she indicated that administration defers to her professional judgement (and the doctor's) on any treatment decisions.

Secure staff identified their first responsibility as protecting the victim and securing medical help. Residents are provided services without financial cost.

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.

Evidence:
HJDH PREA Policy 6.1, XI. Medical and Medical Care, Ongoing medical and mental health care for sexual abuse victims and abusers, pg. 31
Interview with medical staff
Interview with mental health staff

The facility's policy mirrors the standard. There have been no incidents of sexual abuse. Interviews with mental health and medical staff demonstrate knowledge of requirements of the standard. Treatment is consistent with community level of care; medical and mental health professionals are provided to facility under agreement with community based provider. Residents provided treatment services without financial cost. Resident victims of sexually abusive vaginal penetration while incarcerated would be offered pregnancy tests and timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. Evaluations would be done on resident on resident abusers.

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.

Evidence:
HJDH PREA Policy 6.1, XII Data Collection and Review, Sexual violence incident reviews, pg. 31
Interview with superintendent
Interview with PREA Coordinator
Interview with incident review team members

There have been no incidents of sexual abuse at this facility. Facility policy and formation of incident review team both mirror standard. Interviews with members of the team, PREA coordinator, and the superintendent indicate understanding and commitment to the intent of the standard.

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.

Evidence:
HJDH PREA Policy 6.1, XII Data Collection and Review, Data collection, pg. 32-33

Facility policy mirrors standard. There have been no incidents so no data to review. DOJ has not requested any data.

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.

Evidence:
HJDH PREA Policy 6.1 Data review for corrective action, pg. 33
Interview with superintendent
Interview with PREA Coordinator
Review of annual report
Website review

The facility provided its annual report for review. It is posted on the facility's website and is available to the public. It incorporates all elements of the standard. It is approved and signed by the facility superintendent. The report states its right to redact material from the report such as resident names or any identifying information. The report describes what it will collect and the way it reviews the data collected for corrective action.

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.

Evidence:
HJDH PREA Policy 6.1, XII Data Collection and Review, Data storage, publication, and destruction, pg. 33
Interview with PREA Coordinator

Facility policy mirrors standard. There have been no incidents of sexual abuse in prior years. There has been one annual report published. Interview with PREA Coordinator indicated knowledge of the standard and the requirement to both make information publicly available and to remove personal identifiers.

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.

Susan Heck _____ August 10, 2017

Auditor Signature Date