

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim Final

Date of Report 07-31-2019

Auditor Information

Name: David "Will" Weir, MCJ

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Company Name: PREA America

Mailing Address: POB 1473

City, State, Zip: Raton, NM 87740

Telephone: 405-945-1951

Date of Facility Visit: 6-18-2019

Agency Information

Name of Agency

Governing Authority or Parent Agency (If Applicable)

Maryland Department of Juvenile Services

Physical Address: 120 West Fayette Street

City, State, Zip: Baltimore, MD 21201

Mailing Address: Click or tap here to enter text.

City, State, Zip: Click or tap here to enter text.

Telephone: (888) 639-7499

Is Agency accredited by any organization? Yes No

The Agency is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Agency mission: By law, DJS is a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment and after-care services.

Agency Website with PREA Information: www.djs.maryland.gov

Agency Chief Executive Officer

Name: Sam Abed

Title: Agency Secretary

Email: Sam.Abed@maryland.gov

Telephone: 410-230-3101

Agency-Wide PREA Coordinator

Name: Aaron Keech

Title: Agency PREA Coordinator

Email: Aaron.Keech@maryland.gov	Telephone: 301-722-1609
PREA Coordinator Reports to: Jeffery Kessler, Deputy Inspector General	Number of Compliance Managers who report to the PREA Coordinator 13

Facility Information

Name of Facility: Cheltenham Youth Detention Facility
Physical Address: 11003 Frank Tippet Road; Cheltenham, MD 20623
Mailing Address (if different than above): Click or tap here to enter text.

Telephone Number: (301) 782-2400

The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal

Facility Type:	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Correction	<input type="checkbox"/> Intake	<input type="checkbox"/> Other
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Facility Mission: Provide youth with the highest standard of services while encouraging them to prepare for their future, recognize and share responsibilities, respect themselves and others and view self-development as a life-long process.

Facility Website with PREA Information: https://djs.maryland.gov/Pages/PREA.aspx
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Is this facility accredited by any other organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Facility Administrator/Superintendent

Name: Andre Mullings	Title: Superintendent
Email: andre.mullings@maryland.gov	Telephone: 301-782-2413

Facility PREA Compliance Manager

Name: Prince Harmon	Title: Case Management Supervisor
Email: Prince.Harmon@maryland.gov	Telephone: (301) 782-2416

Facility Health Service Administrator

Name: Keva Jackson	Title: Health Administrator
Email: keva.jackson@maryland.gov	Telephone: 410-230-3256

Facility Characteristics

Designated Facility Capacity: 72	Current Population of Facility: 49
Number of residents admitted to facility during the past 12 months	510
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	297
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	392
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	12-18
Average length of stay or time under supervision:	11 days
Facility Security Level:	Hardware Secured
Resident Custody Levels:	Detention
Number of staff currently employed by the facility who may have contact with residents:	112
Number of staff hired by the facility during the past 12 months who may have contact with residents:	24
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	7

Physical Plant

Number of Buildings: 1	Number of Single Cell Housing Units: 7
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	0
Number of Segregation Cells (Administrative and Disciplinary):	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

The complex has a total of 257 cameras. They are located in dayrooms, staff offices, vestibules, incentive rooms, recreation areas, corridors, the commissary, classrooms, entrances, common areas, laundry rooms, the kitchen, dining areas, visitation areas, interview rooms, holding areas, secure areas, lobbies, parking lots, and storage rooms.

Medical

Type of Medical Facility:	Medical Suite (nurse's office and exam room.) Medical is staffed 24 hours, 7 days a week.
Forensic sexual assault medical exams are conducted at:	Prince George's Hospital Center; 3001 Hospital Drive; Cheverly, MD 20785

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	V 15 + C 57 = 72
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	7

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

PREA America's services were retained on November 11, 2017, to conduct the 2019 PREA audit of Cheltenham Youth Detention Facility. Introductory communication with the PREA Coordinator took place shortly after scheduling the on-site audit date, to discuss the audit process, audit preparation, the Pre-Audit Questionnaire (PAQ), supporting documents, and elements of the on-site visit. In February 2019, it was decided to set the on-site date of June 18. Also, a conference call was arranged with facility and agency administrators for April 5. The Audit Notice Posting was sent, with instructions to print on color paper and about proper distribution of the posting. Alternative-language posting was also made available. Proof of posting was verified by emailed photos of the various locations in the facility where the postings were placed. The notices were posted on or before 05-01-2019. The date of the email was used to verify the minimum posting requirements of six weeks, along with observations of the postings during the physical plant tour.

During the Pre-Audit Phase, an extensive desk audit of the facility was conducted, starting on 05-17-2019, when the PAQ and supporting materials were received on a flash drive. Additional emails were exchanged, and phone conferences held, to clarify issues. This phase of the audit was used to collaborate with the facility staff on questions and concerns with documenting compliance. The communication with the facility staff was used not only to understand the policies and procedures unique to the facility, but also how PREA was put into practice. Internet research was done on the facility.

All documents received were reviewed, including logs, training files, and curricula. To verify compliance with requirements for initial background checks and 5-year background checks, including of child abuse registries, files were randomly selected of staff, contractors, and volunteers. Resident files were randomly selected to verify PREA education and PREA Screenings. Phone calls were made to listed advocates, to verify the availability of advocacy and forensic exams as required by the Standards.

Progress toward Memoranda of Understanding (MOU's) for advocacy and forensic services was verified.

The on-site audit started with a briefing, which included confirmation of the current population of 49; review of agenda and logistics; discussion of mandatory reporting; and clarifying the need to allow any staff or resident who requests an interview to get one. The audit team checked to see if there were questions or concerns. The PREA America audit team consists of Project Manager Tom Kovach and DOJ Certified PREA Auditor Will Weir.

The Site Review included obtaining and studying the facility diagram of the physical plant. Staff and residents, and their supervision and movement, were observed. Casual conversations were engaged to ascertain whether observations made were of "normal" supervision and movement. Random checks were made to assure doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance regarding cross-gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high-risk for sexual abuse. PREA Postings in the Visitation area were checked, including third-party reporting postings. Confirmation of the availability to staff of written First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were verified.

Interviews were selected in accordance with the guidance of the PREA Auditor Handbook, with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. 12 of the 49 residents at the facility received private, confidential interviews. 7 of these are considered "targeted" interviews by the PREA Auditor Handbook, because they had at least one factor that, in some cases, may indicate vulnerability to sexual abuse.

Random Staff interviews were made to include gender, shift, and posting diversity. Interviews were in a conversational manner, to gain the confidence of those interviewed and to put them at ease, so that the audit team could better understand their comprehension of PREA and of its practice in the facility. A total of 29 unique private staff interviews were conducted for this audit, not including the SANE Nurse and advocates interviewed to verify services available to residents. However, this number does include 6 interviews with agency administrators, some of which were conducted by phone prior to the on-site audit. 12 Random Staff were interviewed, as well as 12 Specialized Staff. Since Specialized Staff often fill several roles, each were interviewed according to their duties at the facility. Agency and Specialized interviews included: Agency Head Designee; Agency PREA Coordinator; Superintendent; Agency Human Resources; Contractor Monitor; OIG Investigator; OIG Investigator's Supervisor; PREA Compliance Manager; Higher-Level Staff for Unannounced Rounds; Medical Staff; Mental Health Staff; Contractor; Staff who perform Screening and Intake; Staff who monitor for Retaliation; and members of the Incident Review Team.

The Exit briefing addressed all aspects of the audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was summarized. By request of the facility staff, this included a SWOT briefing (a review of Strengths, Weaknesses, Opportunities, and Threats), to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment. Most of the audit activity up to this point indicated many strengths, both at the facility and agency levels. Policies, procedures, and trainings are, for the most part, well-worded and understood. Residents reported getting the education, help, supervision, and support they need. Interviews did, however, indicate a few areas for improvement or clarification. 3 residents believed that calls reporting abuse/harassment might be monitored by the facility. Many staff did not understand terms common in policy, such as "cross-gender", "transgender", and "intersex". Due to the way interview questions were

answered, the subject of consent was identified as a subject on which staff could benefit from training. The training curriculum in use left the issue confusing. Agency and facility administrators acted quickly regarding this feedback from the audit team. New training for Staff clarifying definitions, including consent, was issued and conducted. Regarding consent, it stated, in part, "By law, residents cannot consent while in a confinement setting to staff, volunteers, or contractors. Any sexual activity between staff and residents is considered a violation of PREA and DJS zero-tolerance policy. This is a violation because of the imbalance of power that exists in confinement settings. All sexual activity between youth is prohibited, to include consensual acts." The privacy and confidentiality of telephone calls was made clear. Notices were placed at all unit telephones, stating that PREA calls were not recorded. Resident education on the topic was conducted and completed by the facility case manager. Pictures of the notices and resident acknowledgements of the education was provided to the audit team. Staff training curricula regarding consent, cross-gender searches, and frequently misunderstood terms, were provided to the audit team, along with staff sign-in sheets.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Cheltenham Youth Detention Center originally opened in 1870. In 1937, it was known as the Cheltenham School for Boys. Twelve years later, the facility was renamed Boys' Village of Maryland. The facility was called the Cheltenham Youth Facility from 1992 until 2016, when the new facility opened as Cheltenham Youth Detention Center.

Located in Prince George's County, Cheltenham serves as a secure detention facility for up to 72 male youth who are waiting to go to court or to be placed in a treatment facility. Cheltenham primarily serves male youth from Prince George's, Montgomery, Anne Arundel, Calvert, Charles and St. Mary's Counties.

Cheltenham provides dietary, medical, educational and counseling services, as well as recreational space. In addition to receiving services, youth residing at the facility attend school in the facility. The facility implements a structured behavior management program. All youth receive comprehensive evaluations that include medical, mental health, educational, and substance abuse screening during admission. Specialized programming includes life skills, substance abuse education, and anger management groups. All youth are afforded access to medical services. Recreational, religious, and volunteer programs also are provided, as well as a variety of enrichment activities.

The facility has one building, one main rectangular base with a perpendicular, smaller rectangle and two angled wings, which are the 7 housing units. The 7 housing units are divided into 4 on one wing, and 3 on the other. The housing units are separated by rec areas and a large indoor recreation area between the two wings. Master Control is the central hub, with Food Service, Laundry, Visitation, Administration, Admissions, and Release areas. Behavioral health and school sections are on different sides of Control.

Summary of Audit Findings

The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

Number of Standards Exceeded: 3

Standard 115.316: Residents with disabilities and residents who are limited English proficient; Standard 115.317: Hiring and promotion decisions; and Standard 115.367: Agency protection against retaliation.

Number of Standards Met: 40

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

Cheltenham Youth Detention Center demonstrated compliance in all areas without corrective action.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? Yes No
- Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment? Yes No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? Yes No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? Yes No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? Yes No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) Yes No NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. In addition to including definitions of prohibited behaviors regarding sexual abuse and sexual harassment, this policy includes sanctions for those found to have participated in prohibited behaviors. It describes both the agency's strategies and its responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency employs an upper-level, agency-wide PREA Coordinator, who reports to the Deputy Inspector General. The facility has designated the Case Management Supervisor as the PREA Compliance Manager, and this person answers directly to the Superintendent.

Analysis: Documentation reviewed for compliance with this Standard includes: Facility Operating Procedure; Agency and Facility Organizational Charts; Maryland Department of Juvenile Services (DJS) Policy RF-701-18: Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance, and the associated Procedures; Memos of the appointment of the

Agency-Wide PREA Coordinator; and Memo appointing PREA Compliance Manager, with list of duties. In addition, interviews conducted with the PC, PC's supervisor, PCM, PCM's supervisor, and many other interviews conducted, also serve to verify compliance with this Standard.

Finding: The agency and facility has shown compliance with this Standard.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

When DJS contracts for the confinement of its residents, with private agencies or with other entities including other government agencies, the agency includes the entity's obligation to adopt and comply with the PREA standards.

Analysis: Documentation specifically reviewed for compliance with this Standard includes the contracts for the 4 agencies with which DJS contracts for the placement of youth. The agencies are: The Cornell Abraxas Group (a GEO Group Company); UHS of Delaware, Inc. (d/b/a KidLink Network & Natchez Trace); Mid-Atlantic Youth Services Corporation; and The Summit School, Inc. The past contracts include the required PREA language, as do updated versions of the contracts, which still require full PREA compliance and monitoring but with more explicit language specific to PREA Standards and related DJS policies. Also consistent with this Standard are DJS PREA Policy and Procedures RF-701-18, III A (3); email records related to compliance monitoring (including an email from the Director of DJS Licensing and Monitoring); and the interview with an agency compliance monitor.

Finding: The agency has shown compliance with this Standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? Yes No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? Yes No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? Yes No

- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated)? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? Yes No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? Yes No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? Yes No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) Yes No NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)
 Yes No NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)
 Yes No NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) Yes No NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) Yes No NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? Yes No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? Yes No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) Yes No NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) Yes No NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has developed, documented, and made its best efforts to comply on a regular basis with, a staffing plan that considers all relevant factors, and which provides for adequate levels of staffing and video monitoring, to protect residents against abuse. The average daily number of residents is 39. The average daily number of residents on which the staffing plan was predicated is 72. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. According to the Pre-Audit Questionnaire, interviews, and other documentation received by the auditor, there were no deviations from the plan in the past year. The facility's plan strives to maintain staffing ratios of a minimum of 1:6 during resident waking hours and 1:12 during resident sleeping hours. At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to the staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan, to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment.

Analysis: Interviews, policies, and documentation of practice, provide a triangulation of evidence indicating that the facility is compliant with this Standard. Documentation reviewed for compliance with this Standard includes: Staffing Plans with Shift and Dorm Coverage Reports since 2017 (latest review: May 2019); Facility Staff-to-Youth Ratio Reports from Direct Care Procedure Appendix 2 for 2017-2019; Facility Vulnerability Assessments for years 2017-2019; FOP for Direct Care Staffing; FOP re: Exigent Circumstances to Maintain PREA Ratio; OJT Packet; Blind Spot Listings as of May 2019; Quarterly Facility Surveillance Camera Listings, 2018-2019, with review and repair requests; FOP re: Unannounced Rounds; Unannounced Rounds Log; Staff Schedules; Agency Policy RF-713-14 Direct Care Staffing; Agency Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; and Agency Policy RF-740-17 Supervision and Movement of Youth.

Finding: The facility has shown compliance with this Standard.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
 Yes No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? Yes No NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? Yes No
- Does the facility document all cross-gender pat-down searches? Yes No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? Yes No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) Yes No NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? Yes No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? Yes No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. When referring to persons of the opposite gender performing searches or supervising residents, the Standards and associated policies sometimes refer to this as cross-gender searches, or cross-gender supervision. The facility also has policy consistent with all provisions of this Standard, including prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

Analysis: Documentation reviewed for compliance with this Standard includes: Staff PREA Refresher Logs; Pat-Down Search Brochure; Pat Searches Handout; PREA Pat Searches Performance Checklist; Exigent Circumstances Scenarios; Search Training PowerPoint; Pat-Down Search Step-by-Step Training Guide; Maryland Police and Correctional Training Commissions Lesson Plan; Visual Body Search Brochure; Visual Body Search Training Aid; Executive Directive OP/02-17 Visual Body Searches and Use of Mechanical Restraints During Transports; facility FOPs regarding security, supervision, shower procedures, and searches; DJS Policy RF-712-18 Searches of Youth, Employees, and Visitors; Policy RF-713-14 Direct Care Staffing; Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; Policy RF-740-17 Supervision and Movement of Youth; Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities; DJS Residential Services On-the-Job Manual; and Training Certificates. This multiplicity of documentation, in combination with interviews with staff and residents indicating compliance with this Standard in practice, assisted the audit team to understand the limits of cross-gender viewing and searching at the facility. In addition, the information provided indicated no instances of exigent circumstances which resulted in cross-gender searches in the past year.

However, some staff did not appear to understand terms common in policy, such as “cross-gender”, “transgender”, and “intersex”. During the 30 days after the on-site audit, new training for Staff clarifying definitions relating to supervision and searches was issued and conducted. The staff training curriculum was provided to the audit team, along with staff sign-in sheets. The definitions portion of the training is as follows (emphasis and paragraphs removed; hyphenation added): “PAT-DOWN SEARCH- means a search involving the passing of the hands over the clothed body of. Staff conducting pat-down search must be same gender as youth. DJS Policy and Procedures: Male staff search male youth and female staff search female youth. CROSS-GENDER PAT-DOWN SEARCHES- means a search involving the passing of the hands over the clothed body of by the staff of the opposite gender. Cross-gender pat-down searches are prohibited. Staff shall not conduct cross-gender pat-down searches except in exigent circumstances. When an employee of the same gender as the youth being searched is not available, the youth shall be kept under constant visual supervision until the same-gender staff is available to perform the search, unless, as determined by the Superintendent or designee, an exigent circumstance exists, temporary, unforeseen, and threatens the safety and security of the facility, staff or other youth and dictate[s] an immediate pat-down search of the youth. Searches made under justified exigent circumstances must be approved by the Superintendent and documented in the unit and facility log book. (Cross-gender = opposite gender)[.] TRANSGENDER- means a person whose gender identity is different from the person’s assigned sex at birth. INTERSEX- means a person whose sexual and reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as disorders of sex development.”

Finding: The facility has shown compliance with this Standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of

first-response duties under §115.364, or the investigation of the resident's allegations?

Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has established procedures to provide disabled residents, and residents with limited English proficiency (LEP), equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy prohibits use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances, where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations. If there ever are exceptions, the agency documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used; however, in the past 12 months, there have been none. Exceeding the minimum requirement of the standard, the agency provides contract interpreters all day for LEP residents, not just when there is a required need. Interpreters accompany the youth to class and assist them in various ways throughout the day and into the evening.

Analysis: Documentation reviewed for compliance with this Standard includes: ADA and LEP Monthly Monitoring Reports from 2018 to 2019; Contracts with Ad Astra, Interpreters Unlimited, Schreiber, & LanguageLine Telephonic; DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities; Policy OPS-920-18 Communication with Limited English Proficient Persons; Policy MGT-625-14 Nondiscrimination of Youth; Youth Handbook in English and Spanish; Challenge Program Manual for Youth; Interpreter Flashcards; Memo regarding Language Providers; LEP Coordinators List; Request Form for Auxiliary Aids; and "What You Should Know About Sexual Abuse and Harassment" in English and Spanish. Besides the interpreters and special education services, interviews with staff and residents revealed other times and ways residents are given assistance, whether it be with emotional or intellectual needs. There are daily and weekly groups that assist in various ways with problem-solving and skills-building. Unit Managers help with contacting family and writing letters. Residents report that staff make sure residents are OK, and that they feel safe, regardless of who they are, or what their background is like. Staff don't mind repeating something if it is not understood, or wording it a different way. Staff have skills to assist when someone is upset, rather than making it worse like in jails and other facilities some of the youth have been to.

Finding: The facility has shown compliance with this Standard and has exceeded the Standard.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? Yes No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? Yes No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? Yes No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? Yes No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? Yes No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? Yes No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? Yes No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing

information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Maryland Department of Juvenile Services has an overarching policy, mandatory for all public and contracted facilities, which requires annual criminal background checks and annual checks of a central registry of abuse and neglect. Moreover, the agency specifically requires and monitors for compliance with this for all Juvenile Services residential facilities.

Analysis: Documentation reviewed for compliance with this Standard includes: Staff Disclosure Forms for 2018-2019; Vendor contracts requiring background checks; 8 Randomly selected contractor and employee files reviewed for Background Checks and Child Registry Checks; DJS Policy RF-701-18 IIIA (4) and (5); DJS Policy HR-410-18; PREA-Mandated Disclosure Form; Overview of Hiring Mandated Employees Letter; and New Hire List 2017-2019. The Human Resources Director explained that before being hired, the prospective employee gets interviewed, by an investigator and by a psychologist. They then get a CAR Check and a Fed/State Background Check, which provide continual updates for any violations, including motor vehicle violations/tickets. Policy reviews, interviews, and reviews of random employee files verify the agency significantly exceeds the minimum standard.

Finding: The agency exceeds the requirements of this Standard.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing

facilities since August 20, 2012, or since the last PREA audit, whichever is later.)

Yes No NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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CYDC, which opened in 2017 after being newly constructed, replaced the adjacent Cheltenham Youth Facility.

Analysis: Documentation reviewed for compliance with this Standard includes: Camera lists and functionality audits; facility schematic; DJS Policy RF-701-18 III (I); and CYDC Overview. Interviews conducted, the site review, and video monitoring review, contribute to a finding of compliance with this Standard.

Finding: The facility has shown compliance with this Standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
 Yes No NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? Yes No
- Has the agency documented its efforts to secure services from rape crisis centers?
 Yes No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) Yes No NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Administrative investigations are typically conducted by the Office of Inspector General and Child Protective Services. They coordinate on the criminal investigations, which are typically completed by

the Maryland State Police. The police follow uniform evidence protocol. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. During the past 12 months, there have been no forensic medical exams conducted. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means, and documents these efforts. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Youth Grievance Policy OPS-907-15; SARS Qualified Staff List; Coordinated Response Plan; SARS Training Memo; SARS Protocol; SARS Training Material and Advance Training Material; SARS Training Sign-in Sheets; emails about training; Maryland State Attorneys Contact List; SAFE/FNE List; MCASA MOU; documented attempts to engage other advocacy organizations in MOU's; Mental Health Licenses List and Certificates; Maryland Forensic Exam Regulations; DJS Policy RF-701-18 (III 4, d); Maryland State Police (MSP) Guidelines for Physical Evidence and Incidents in Facilities; COMAR 10.27.21.3; Email documenting "No Charge for Medical Procedures"; and Maryland VAWA Forensic Compliance Guidelines. In addition to interviews with agency and facility personnel, the audit team interviewed the area SANE Coordinator, and community-based providers, to verify services are in place for residents as required by this Standard. The regional system includes a network of forensic medical professionals qualified to do sexual abuse exams, and they work closely with the Child Advocacy Centers. The SANE Coordinator said that, once the on-call SANE is contacted, the second call is always to secure advocacy for any alleged victim they are helping.

Finding: The facility has shown compliance with this Standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? Yes No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? Yes No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? Yes No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
 Yes No NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency ensures that administrative or criminal investigations are completed for all allegations of sexual abuse and sexual harassment. When referrals are received, they are referred to the agencies with legal authority to conduct the investigations. Policies related to this Standard are publicly available.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 III D; OPS-913-15 Reporting and Investigating Child Abuse and Neglect; documentation of reports of sexual abuse and harassment agency wide; and the DJS Website. Interviews with the agency head designee, investigative staff, and PREA administrators provided details of how the agency ensures that referrals are received, documented, referred for investigations, and then tracked.

Finding: The facility has shown compliance with this Standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? Yes No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment Yes No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? Yes No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? Yes No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?
 Yes No
- Is such training tailored to the gender of the residents at the employee's facility? Yes No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? Yes No

115.331 (c)

- Have all current employees who may have contact with residents received such training?
 Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency trains all employees who may have contact with residents on all required matters consistent with this Standard, and more. All staff who may have contact with residents have been trained within the past 12 months.

Analysis: Documentation reviewed for compliance with this Standard includes: Facility FOP and MDJS policy (RF-701-18) requiring training; Mandated Training Spreadsheet; Training Logs; Admission and Orientation Training; PREA Training and PREA Refresher Training; Training Activity Documents; 2019 Proposed Training Updates; LGBTQI Terms; Boundaries Training; PREA Pocket Guide; 2017 and 2018 Training Curriculum; and training acknowledgments and test scores. Staff who had been randomly selected for interviews were questioned regarding the training they received, and they verified that they had received all the training they were asked about, and usually demonstrated an understanding of the training during the interview. However, some staff did not understand terms common in policy, such as “cross-gender”, “transgender”, and “intersex”. Due to the way interview questions were answered, the subject of consent was identified as a subject on which staff could benefit from training. The training curriculum in use left the issue confusing. Agency and facility administrators acted quickly regarding this feedback from the audit team. New training for Staff clarifying definitions, including consent, was issued and conducted. Regarding consent, it stated, in part, “By law, residents cannot consent while in a confinement setting to staff, volunteers, or contractors. Any sexual activity between staff and residents is considered a violation of PREA and DJS zero-tolerance policy. This is a violation because of the imbalance of power that exists in confinement settings. All sexual activity between youth is prohibited, to include consensual acts.” Staff training curricula regarding consent, cross-gender searches, and frequently misunderstood terms, were provided to the audit team, along with staff sign-in sheets.

Finding: The agency and facility have shown compliance with this Standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures? Yes No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? Yes No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The agency maintains documentation confirming that volunteers/contractors understand the training they have received. At CYDC contractors are utilized as school staff, interpreters, and medical and mental health providers. Volunteers regularly provide faith-based services and group activities, and they also provide occasional arts, crafts, music and recreational activity.

Analysis: Documentation reviewed for compliance with this Standard includes: PREA Training for Contractor and Employee Check-Off List; FOP Employee Training; DJS Policy MGT-640-18; Policy RF-701-18; signed contracts with volunteers; 2 randomly selected contractor background check files; Facility Programming Chart, with dates and names of all volunteers trained; PREA Training for Volunteers; Training and acknowledgements from interpreters; PREA Exams and training rosters; Policy OPS-908-14; Policy OPS-913-15; and Facility Training Chart for Programming. In addition to interviewing contractors, the audit team interviewed staff who supervise them. All information and interviews were consistent with compliance with this Standard.

Finding: The facility has shown compliance with this Standard.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? Yes No
- Is this information presented in an age-appropriate fashion? Yes No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? Yes No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? Yes No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? Yes No

115.333 (c)

- Have all residents received such education? Yes No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
 Yes No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? Yes No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions?
 Yes No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC residents receive information regarding the zero-tolerance policy, and about how to report incidents or suspicions of sexual abuse or sexual harassment. Of residents admitted during the past 12 months, all were given this information at intake in an age-appropriate fashion. All other residents have received the training, as well, and each has signed that they understand the training. They have been educated regarding their rights, such as to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. Key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

Analysis: Documentation reviewed for compliance with this Standard includes: End the Silence Curriculum; Resident Education Groups Acknowledgements; Youth Intake Packets; Files with Screenings for Youth; DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities; FOP for Resident Training; PREA Posters; DJS Website; "What You Should Know" brochures; and education and screening documentation for youth that have been at Cheltenham in the past 12 months. Interviews were conducted of random residents and staff, as well as of staff who do admissions. Also, of importance to verifying compliance with this Standard was the PREA Site Review, during which the audit team was able to confirm that postings and materials were up and available. The only topic identified for additional focus was regarding the issue of the confidentiality of resident reports of sexual abuse/sexual harassment. 3 residents believed that calls reporting abuse/harassment might be monitored by the facility. Agency and facility administrators acted quickly regarding this feedback from the audit team. Actions were taken during the 30 days after the on-site audit to assure that the privacy and confidentiality of telephone calls was made clear. Notices were placed at all unit telephones stating that PREA calls were not recorded. Resident education on the topic was conducted and completed by the Facility Case Manager. Pictures of the notices and resident acknowledgements of the education were provided to the audit team.

Finding: The facility has shown compliance with this Standard.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] Yes No NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In addition to the general training provided to all employees, the agency requires its investigators to receive training in conducting sexual abuse and sexual harassment investigations in confinement settings, including all the provisions of this Standard. These investigations are conducted by investigators from the Office of Inspector General. Investigations conducted by facility-level investigators are not those involving allegations of sexual abuse or sexual harassment.

Analysis: Documentation reviewed for compliance with this Standard includes: NIC Specialized Training Memo and Certificates of Completion; List of Contacts for Child Abuse Allegations; DJS Policy: RF-701-18 III A 6; MSP Barracks contact information; MSP Operations Directive: Response By Criminal Investigators; CPS Office contacts; and investigations performed by the agency. The audit team interviewed agency OIG investigators and administrators and found them to be very knowledgeable regarding this Standard, consistent with the training they have received. The auditor verified that all investigations regarding sexual abuse and/or sexual harassment that had been done by the agency had been completed by an appropriately trained investigator.

Finding: The facility and agency has shown compliance with this Standard.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? Yes No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? Yes No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? Yes No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? Yes No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) Yes No NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? Yes No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? Yes No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has a policy related to the training of medical and mental health practitioners who work regularly in the facility, all 25 of whom have received the training, albeit that they do not do forensic exams. The agency maintains documentation showing that medical and mental health practitioners

have completed required training. The training teaches how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Analysis: Documentation reviewed for compliance with this Standard includes: NIC Training Certificates; Mental Health Licenses; PREA Mandated Training Form; Policy RF-701-18 III A 6; Refresher Training Chart; and SAFE Hospital List. Interviews with Medical and Mental Health Staff indicate these staff understand these tasks and responsibilities.

Finding: The facility has shown compliance with this Standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? Yes No
- Does the agency also obtain this information periodically throughout a resident's confinement? Yes No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? Yes No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? Yes No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? Yes No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? Yes No
- Is this information ascertained: During classification assessments? Yes No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? Yes No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? Yes No

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has a policy that requires screening upon admission for risk of sexual abuse victimization or sexual abusiveness toward other residents, using an objective screening instrument. In actual practice, the screenings, called Vulnerability Assessment Instruments, are typically done within the first few hours of the resident’s arrival. Also, the policy requires that a resident’s risk level be reassessed periodically throughout their confinement. When reassessments are done, a housing reassessment is also completed.

Analysis: Documentation reviewed for compliance with this Standard includes: Youth Vulnerability Assessment Instruments (Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk) conducted for the past 12 months; DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities (III D); FOP Admissions and Orientation of Youth (III A); DJS Policy RF-716-18 Classification of Youth in DJS Residential Facilities; FOP regarding Classification of Youth; Housing Classification Assessment and Re-Assessment Forms; Screening Tool; DMST Screening Tool; DJS Facility Initial Reception/Referral Screening Tool (FIRRST); Youth Vulnerability Assessment Instrument; Bed Chart; and Facility Schematic. Interviews with the staff who conduct screenings, and residents, as well as the PC and PCM, indicate that the practice at CYDC is consistent with the documented screenings and other documentation reviewed.

Finding: The facility has shown compliance with this Standard.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? Yes No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? Yes No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? Yes No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? Yes No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? Yes No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? Yes No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? Yes No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? Yes No
- Do residents in isolation receive daily visits from a medical or mental health care clinician? Yes No
- Do residents also have access to other programs and work opportunities to the extent possible? Yes No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? Yes No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? Yes No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? Yes No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? Yes No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? Yes No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? Yes No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) Yes No NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) Yes No NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments. This information is gleaned through conversations with the resident and during medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s file.

Analysis: Documentation reviewed for compliance with this Standard includes: Youth Vulnerability Assessment Instruments (Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk) conducted for the past 12 months; DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities (III D); FOP Admissions and Orientation of Youth (III A); DJS Policy RF-716-18 Classification of Youth in DJS Residential Facilities; FOP regarding Classification of Youth; Housing Classification Assessment and Re-Assessment Forms; Screening Tool; DMST Screening Tool; DJS Facility Initial Reception/Referral Screening Tool (FIRRST); Youth Vulnerability Assessment Instrument; Bed Charts/Rosters; Housing Classification User’s Guide; and Facility Schematic. Interviews with the staff who do housing and programming assignments, and residents, as well as the PC and PCM, indicate that the practice at CYDC is to utilize available information appropriately to protect residents, while keeping the information confidential.

Finding: The facility has shown compliance with this Standard.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? Yes No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? Yes No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? Yes No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? Yes No
- Does that private entity or office allow the resident to remain anonymous upon request? Yes No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? Yes No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? Yes No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DJS has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents can report verbally, through the grievance process, or through the outside reporting options. The facility does not house any residents detained solely for civil immigration purposes, so parts of this standard are non-applicable. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Agency policy and facility operating procedures reviewed are consistent with this standard, as are staff training curriculum and resident education requirements.

DJS has an MOU with 2-1-1 Maryland, Inc., to provide residents with an outside reporting option. Postings prominently placed on walls, and in various materials, provide instructions to "Dial 211" to reach the "Sexual Abuse Hotline." Then readers are provided more information, such as, "The Department of Juvenile Services has a ZERO TOLERANCE Policy for any form of sexual abuse or sexual harassment. Sexual activity is prohibited. If you feel threatened or are fearful of harm report it immediately. You can tell your case manager, unit staff, medical staff, teachers, supervisors, child advocate, your parent or guardian, or any other trusted adult. Your concerns will be addressed promptly in a professional manner. You may also report sexual abuse and sexual harassment using the Sexual Abuse Hotline. The Sexual Abuse Hotline was created so that you will be able to report sexual abuse or sexual harassment confidentially. The Hotline is an outside agency that will receive your concern and ensure that it is reported to Child Protective Services for investigation. The Hotline will also inform the Department of Juvenile Services so that steps can be taken immediately for your protection. It is important to us that you are safe and free from all types of abuse during your placement. The Sexual Abuse Hotline is available 24 hours each day, 7 days a week. If you have been, or know someone who may have been abused or harmed, tell a trusted adult immediately or call the Sexual Abuse Hotline by dialing 211."

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities (III A 6 & 9, B, & F 6); Policy OPS-913-15 Reporting and Investigating Child Abuse and Neglect; Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; Youth Handbook; Dialing Instructions in English and Spanish; STARR Program Manual; Hotline MOU; and the sections in staff training regarding this Standard. Randomly selected staff and residents were questioned about parts of this Standard, as well as the PREA Compliance Manager. These interviews were consistent with the documentation reviewed, and postings observed during the Site Review, indicating residents can make reports in a variety of ways, and are told how to do so.

Finding: The facility has shown compliance with this Standard.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. Yes No NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension,

may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
 Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) Yes No NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
 Yes No NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) Yes No NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA

- Does the initial response and final agency decision document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency’s final decision document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has an administrative procedure for dealing with resident grievances regarding sexual abuse which allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The policies and procedures conform to all provisions of this Standard. While the system is set up to accept grievances alleging sexual abuse, once these grievances are received, they are handled according to PREA policy, rather than continuing to be processed totally within the grievance system. Policy OPS-907-15 states, in the first paragraph, “The Department of Juvenile Services (DJS) shall ensure youth and individuals acting on behalf of DJS youth can file a grievance for a situation related to behavior of other youth or staff, contractors or volunteers, or to the conditions of confinement. If the youth initiates a grievance alleging abuse, neglect, sexual abuse or mental injury, the Department’s Youth Advocacy Unit will not handle that grievance but will instead report the incident to Child Protective Services (CPS), the Maryland State Police, and the DJS’ Office of the Inspector General (OIG) for immediate investigation. Grievances do not replace staff responsibility for reporting abuse, neglect, sexual abuse or mental injury.” Then, on page 5 of the policy, Direct Care Staff Responsibilities include, “Report allegations of sexual abuse or

harassment in accordance with the DJS PREA - Elimination and Reporting of Sexual Abuse and Harassment Policy and Procedures, if the youth indicates to the staff that this subject is the nature of the grievance.” Since sexual abuse and harassment allegations are reported outside the grievance system, the grievance system timelines do not apply to these types of allegations. However, policy requires emergency grievances “be resolved within eight hours of receipt. A verbal response must be followed with a written response within 48 hours of receipt to the youth and the Director of the Youth Advocacy Unit.”

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-715-18; Policy OPS-913-15; Policy RF-701-18; Policy OPS-907-15; FOP 14.1; Youth Assessment; Letter from Youth Advocate; Grievance Forms; and Memo from PREA Coordinator. The content of interviews with youth, staff and administrators, as well signage observed during the Site Review, go together to indicate the grievance system is in working order, although there have been no known emergency grievances, and all sexual abuse and sexual harassment allegations are sent to OIG, CPS, and/or law enforcement for investigation. The portions of grievances that allege sexual abuse or sexual harassment are not investigated within the grievance system.

Finding: The facility has shown compliance with this Standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? Yes No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? Yes No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? Yes No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? Yes No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? Yes No
- Does the facility provide residents with reasonable access to parents or legal guardians? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents are provided access to outside victim advocates for emotional support services related to sexual abuse. They are provided with phone numbers upon admission, as well as by postings around the building. They are assisted in communicating with these organizations, in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The agency maintains documentation regarding attempts to enter into memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. Forensic exams are conducted at Prince George's Hospital Center in Cheverly, MD. Advocacy for survivors is available from the Child Advocacy Center. Advocacy is coordinated throughout the state by the Maryland Coalition Against Sexual Assault (MCASA), and is also triggered by the SANE Coordinator for the region when a request is received for a forensic exam.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III A 9); Policy RF-706-18 Visitation; Maryland Department of Mental Health and Hygiene Website; MCASA MOU update and Letter; Hotline Posting and “What You Should Know”; Hotline Dialing Instructions; FOP Youth Access to Telephone Calls, Mail, Legal Counsel, and Notification of Family Death or Illness; Resident Education Lesson Component: Outside Counseling Services; FOP Youth Assessment; documented attempts to develop additional advocacy MOU; OPS-913-15; DJS Website; Third-Party Posting; and Third-Party Reporting Diagram. These resources have been verified by phone and internet research by the audit team.

Finding: The facility has shown compliance with this Standard.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Third-party reports can be made through the grievance system, through the reporting line, or by verbal or written reporting to the facility or agency. The agency and facility publicly distribute information on how to report resident sexual abuse or sexual harassment on behalf of residents. Information is provided to the resident and resident’s family upon admission.

Analysis: Documentation reviewed for compliance with this Standard includes: Youth Orientation and Postcard; Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; Policy OPS-913-15 Reporting and Investigating Child Abuse and Neglect; Third-Party Reporting Page on the agency website; Third-Party Postings with Office of the Inspector General number (1-855-821-2103); and Third-Party Reporting Diagram. The site review verified that Third-Party information is available in visitation areas. Staff and residents interviewed knew that reports can be received through other people, even through people outside the facility; that reports can be made anonymously; and that reports can be made through outside organizations. Posters list the CPS toll-free number and other reporting options, the information is included in youth and staff training, and the information is listed on the Maryland Department of Juvenile Services Website.

Finding: The facility has shown compliance with this Standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? Yes No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? Yes No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? Yes No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? Yes No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? Yes No
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) Yes No NA
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? Yes No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC requires all staff to report immediately and according to agency policy: any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; any retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local service agencies, Maryland DJS policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are mandated reporters and are required to inform residents at the initiation of services, both of their duty to report and of the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility will promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report will be made to the alleged victim's caseworker instead of to the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III A, B, & K); Policy OPS-913-15 Reporting and Investigating Child Abuse and Neglect; Policy OPS-900-15 Incident Reporting—Residential Facilities and Community Operations; FOP Incident Reporting; Incident Reporting Form; COMAR Reporting Standard; and Family Statute Title 07 02. Interviews with Investigators, as well as agency and facility administrators, indicate these policies are being followed. Line Staff, as well as Medical and Mental Health Staff, also indicate no barriers or lack of compliance.

Finding: The facility has shown compliance with this Standard.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

When the CYDC learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident.

Analysis: Documentation reviewed for compliance with this Standard includes DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III C). According to the Pre-Audit Questionnaire, in the past 12 months, there was one time the facility determined that a resident was subject to risk of imminent sexual abuse. Staff interviewed indicate that, depending on the specifics of the information received about the substantial risk of harm, they would follow as many of the First Responder Protocols as might apply to the situation. The facility treats every allegation as a potential substantial risk situation. Compliance was established with a review of documents, policy, and interviews, including the interviews with the Superintendent, with the PREA Compliance Manager, and with the PREA Coordinator.

Finding: The facility has shown compliance with this Standard.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? Yes No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency? Yes No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? Yes No

115.363 (c)

- Does the agency document that it has provided such notification? Yes No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Superintendent must notify the head of the external facility, or the appropriate office of the agency or facility where sexual abuse is alleged to have occurred, as soon as possible, but no later than 72 hours after receiving the allegation; and that this notification be documented. Policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, there have been no allegations that the facility received that a resident was abused while confined at another facility. Allegations received from other facilities/agencies are to be investigated in accordance with the PREA standards. In the past 12 months, there have been no allegations of sexual abuse that were received from outside facilities.

Analysis: Documentation reviewed for compliance with this Standard includes: Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (Part B Reporting); Policy OPS-900-15 Incident Reporting-Residential Facilities and Community Operations (Part B General Reporting Guidelines); and DJS Regional Map, with Regional Director's List and Regional Resource Offices. Interviews with the Agency Head Designee, Superintendent, and PREA administrators indicated a clear understanding of the specifics of this Standard. Other staff had a general understanding regarding their reporting duties.

Finding: The facility has shown compliance with this Standard.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has a First Responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report is required to separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing

teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and if the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Policy requires that if the first staff responder is not a security staff member, that responder is required to request that the alleged victim not take any actions that could destroy physical evidence and notify security.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-15 & 18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance; the CYDC Coordinated Response Plan; and staff training materials. Interviews conducted, and documentation received by the audit team, indicate staff and administrators have recently reviewed these duties, have hard copies of them, and are familiar with them.

Finding: The facility has shown compliance with this Standard.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC has developed a very detailed written institutional plan to coordinate actions taken, among staff first responders, medical and mental health practitioners, investigators, and facility leadership, in response to an incident of sexual abuse.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 C 2; FOP 18.9 Staff First Responder's and Coordinated Response to Sexual Abuse and Harassment Incidents; Maryland State's Attorneys (list); DJS Qualified Staff Member List: DJS Sexual Assault Responder/Support (SARS) Staff; SARS Notification Protocol; Maryland Coalition Against Sexual Assault (MCASA) Sexual Assault Forensic Examiners/Forensic Nurse Examiners (SAFE/FNE); DHR/SSA 180 (CPS reporting form); and Facility Coordinated Response Plan. Interviews indicated that staff and administrators are generally aware of the contents of the CRP and know where to find it when they need to reference it.

Finding: The facility has shown compliance with this Standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has renewed their collective bargaining agreement and maintains the ability to protect residents from abusers.

Analysis: Documentation reviewed for compliance with this Standard includes: Collective Bargaining Agreement documentation for AFT HealthCare-Maryland Local 5197; the Maryland Professional Employees Council/AFT/AFL-CIO Local 6197; and the American Federation of State, County and Municipal Employees, AFL-CIO and Teamsters Union. Information received throughout this audit, and interviews conducted, indicated no lack of compliance with this Standard.

Finding: The facility and agency have shown compliance with this Standard.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? Yes No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? Yes No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks?
 Yes No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
 Yes No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DJS has a policy to ensure the protection of all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. Exceeding the minimum requirements of this standard, the agency: (1) designates duplicate administrative staff with official duties of monitoring for possible retaliation; (2) mandates that everyone keeps possible retaliation in mind; and (3) documents this monitoring on a weekly basis. The PREA Compliance Manager and OIG Youth Advocates monitor the conduct and treatment of residents or staff who reported sexual abuse, and of residents who were reported to have suffered sexual abuse, to see if there are any changes that may suggest possible retaliation by residents or staff, for 90 days or as long as needed.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III K); Policy OPS-913-15 Reporting and Investigating Child Abuse and Neglect; Youth Advocate Retaliation Monitoring Form; and PREA Compliance Manager Retaliation Monitoring Form. The file of the one allegation that occurred at the facility was reviewed. Retaliation monitoring is not required by the Standard after a finding of unfounded, as was the case here. However, documentation regarding this case shows that the file was reviewed, and protocols are in place for the Family Advocate to be notified "of all allegations for their follow-up regardless of the investigation/allegation outcome." In excess of the minimum requirements of this Standard, the facility provided some retaliation monitoring oversight even in a case determined to be unfounded. The audit team reviewed documentation completed by the OIG regarding incidents that occurred in other agency facilities, as well. The facility and OIG Youth/Family Advocates each demonstrate that they employ duplicate multiple protection measures, and they document these weekly, rather than monthly as required by the Standard.

Finding: The facility has significantly exceeded the minimum requirements of this Standard.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? Yes No

Auditor Overall Compliance Determination

Exceeds Standard (Substantially exceeds requirement of standards)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are protocols in policy for youth at CYDC who indicate risk of being victimized or abusive. This includes housing decisions regarding any youth who may be alleged victims of sexual abuse. These protocols start upon the youth’s arrival and are shaped by information about each youth, and by behavior. Interviews and documentation reviewed indicate that CYDC has been able to adequately protect alleged victims of abuse, during the last 12 months, without the use of segregation. Nonetheless, if the need should arise, a degree of brief segregation is allowed for in policy (Policy RF-716-18 DJS Classification of Youth in DJS Residential Facilities, Section B). The other subsections of § 115.342 are also specifically addressed in policy.

Analysis: Documentation reviewed for compliance with this Standard includes the above-referenced policy; DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III F); and the FOP for At Risk Youth. In addition to the documentation reviewed; and the Site Review, which showed single-occupancy rooms; interviews with the Superintendent, staff who supervise residents, medical staff, and mental health staff indicated full compliance with this Standard. Furthermore, youth indicated knowledge of how the system works and explained to the auditor that no youth would be segregated from other youth for any reason for very long, and that the Facility would never allow them to avoid their education, or deny them medical care, or mental health care.

Finding: The facility has shown compliance with this Standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] Yes No NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] Yes No NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? Yes No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? Yes No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? Yes No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? Yes No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? Yes No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? Yes No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DJS has a policy related to criminal and administrative agency investigations that meet all the provisions of this Standard. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. The substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is a resident or is employed by the agency, plus five years. The Office of the Inspector General usually conducts the facility's administrative investigations. CPS also conducts administrative investigations when the allegation meets their criteria. Law enforcement conducts criminal investigations. When the quality of evidence appears to support criminal prosecution, the agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and not determined by the person's status as resident or staff. The departure of the alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation. No resident who alleges sexual abuse will have to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. When outside agencies investigate sexual abuse, the facility cooperates and endeavors to remain informed about the progress of the investigation.

Analysis: Documentation reviewed for compliance with this standard include the CPS Contact List; Coordinated Response Plan, and DJS Policy: RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III D). Interviews, and a review of investigative documentation agency wide, indicate that the agency does these investigations promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. These administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. The investigations are documented in written reports, which include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Finding: The agency and facility have shown compliance with this Standard.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy: RF-701-18 III D; MD State Personnel Code 11-101 (103); and investigation files. Interviews indicated that the investigators and administrators also understand and comply with this Standard.

Finding: The facility and agency have shown compliance with this Standard.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? Yes No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.373 (c)

- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit? Yes No
- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? Yes No
- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? Yes No
- Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? Yes No

115.373 (d)

- Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
 Yes No
- Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
 Yes No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? Yes No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy requires that any resident who makes an allegation that he suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. If an outside entity conducts an investigation, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever the agency learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy: RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (E); and Appendix 6-Youth Notice of Investigative Outcome. In the past 12 months, there has been 1 administrative investigation of alleged sexual abuse or harassment. Compliance with this Standard was verified through interviews, review of policy, and a review of investigative documentation, including the notification made to the alleged victim in the completed investigation.

Finding: The facility has shown compliance with this Standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? Yes No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? Yes No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? Yes No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC staff are subject to disciplinary sanctions, up to and including termination, for violating sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Termination is the

presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy MGT-03-18 Sexual Harassment/Employment Discrimination Policy (III A); RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment- PREA Juvenile Facility Standards Compliance (III H); and DJS Standards of Conduct and Disciplinary Process. Interviews with HR, as with agency, OIG, and facility administrators, also verify compliance with this Standard. In the past 12 months, no staff have been found to have violated agency sexual abuse or sexual harassment policies. One allegation regarding sexual abuse by staff was investigated and determined to be unfounded, so no disciplinary sanction of staff was indicated. The investigative file was reviewed and included a thorough and objective investigation, including all the required components of sexual abuse investigations.

Finding: The facility has shown compliance with this Standard.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? Yes No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies, and the understanding of facility practices explained during interviews, indicate that any contractor or volunteer found to have engaged in sexual abuse would be reported to law enforcement agencies and to relevant licensing bodies. Policy clearly requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, there have been no allegations or reports regarding volunteers. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Analysis: Documentation reviewed for compliance with this Standard includes: Facility Programming Chart; DHS Policy: RF-701-18 III (I); OPS-908-14; Volunteer List; and investigative files regarding sexual abuse and/or sexual harassment investigations conducted by OIG in the past 12 months. Interviews with supervisors and other administrators indicate compliance with this Standard.

Finding: The facility has shown compliance with this Standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?
 Yes No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? Yes No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? Yes No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? Yes No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? Yes No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? Yes No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? Yes No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? Yes No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process, following an administrative finding that the resident engaged in resident-on-resident sexual abuse, or a criminal finding of guilt. The following is an excerpt from their Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance Policy (NUMBER: RF-701-18):

"J. INTERVENTIONS AND DISCIPLINARY SANCTIONS FOR YOUTH

1. Youth may be subject to sanctions pursuant to the behavioral management program following an administrative finding that the youth engaged in youth-on-youth sexual abuse or following a criminal finding of guilt for youth-on-youth sexual abuse.
2. The disciplinary process shall be documented on a behavioral report and consider whether a youth's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.
3. Facility staff shall determine the appropriate intervention, therapy and/or counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. The QBHP [Qualified Behavioral Health Professional] shall consider whether to offer such interventions to the perpetrator. The facility may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access general programming or education.
4. The facility may discipline a youth for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
5. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
6. All sexual activity between youth is prohibited, to include consensual acts. The facility may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.
7. Incidents of alleged abuse and harassment may be referred to MSP [Maryland State Policy] for determination of criminal charges."

Analysis: Documentation reviewed for compliance with this Standard includes the policy quoted above, and DJS Policy RF-716-18 Classification of Youth in DJS Residential Facilities, as well as training and educational materials distributed to staff and youth. Interviews with investigators and facility administrators indicate an understanding of this Standard. In the past 12 months, there have been no allegations of resident-on-resident sexual abuse or sexual harassment at CYDC. Files were reviewed regarding other agency facilities which utilize the same OIG investigators, and the agency and facility appear to be compliant with the requirements of this standard.

Finding: The facility has shown compliance with this Standard.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? Yes No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? Yes No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? Yes No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All residents at CYDC who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening, as per the facility's written policy and procedure. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Mental health staff maintain secondary materials documenting compliance with the above required services. Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, and its use is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

Analysis: Documentation reviewed for compliance with this Standard includes the Behavioral Health Referral Form (with verification that the youth was seen); Medical Administration Initial Care Report; Health Status Alert Form (with confidentiality warnings); MDJS History and Physical Examination; Initial Service Treatment Plan; MDJS Youth Admission Intake Questionnaire; MDJS Tuberculosis Screening Form for Youth (with Follow-up Form including Ebola); MAYSI Questionnaire; MDJS Nursing Assessment – 30-Day Review; MDJS Health Services Division Physician Order Sheets; MDJS Pre-Admission Medical Assessment Form (for use if youth flags on the FIRRST Form); MDJS Refusal of Treatment; SASSI; Vaccine Administration Record; Behavioral Health Assessment; MDJS Safety Plan for Alleged Sexual Abuse; MDJS Admission Health Screening and Nursing Assessment; MDJS Allowance of Disclosure; MDJS Progress Notes; and DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment- PREA Juvenile Facility Standards Compliance (III G). Policy reviews, interviews with staff and administrators, and reviews of documentation of these screenings being conducted, provided verification to the auditors of compliance with this Standard.

Finding: The facility has shown compliance with this Standard.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? Yes No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? Yes No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners? Yes No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? Yes No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Documentation is maintained by medical and mental health staff of the following: the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. Treatment services are provided to every victim without financial cost, and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. CYDC residents are served by Prince George's Hospital Center in Cheverly, MD.

Analysis: Documentation reviewed for compliance with this Standard includes Behavioral Health Referral; Behavioral Health Referral Response Form; Nursing Screening and Assessment; Nursing Report of Youth Injuries; Nursing Assessment – 30 Day Review; Safety Plan for Alleged Sexual Abuse; Chain of Custody of Medication Transferred; Email confirming Free Medical Exam, Coordinated Response Plan; and DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment- PREA Juvenile Facility Standards Compliance (III C 4, and G 7). In addition to interviews with agency and facility personnel, the audit team interviewed the area SANE Coordinator, and community-based providers, to verify services are in place for residents as required by this Standard.

Finding: The facility has shown compliance with this Standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? Yes No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? Yes No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? Yes No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) Yes No NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) Yes No NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? Yes No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
 Yes No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim without financial cost, and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews indicate that the evaluation and treatment of victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and it offers treatment when deemed appropriate by mental health practitioners.

Analysis: Documentation reviewed for compliance with this Standard includes: DJS Policy RF-701-18 Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance (III C4, & G); Behavioral Health Referral; Behavioral Health Referral Response Form; Chain of Custody of Medication Transferred; Medical Summary for Consideration of Placement; Maryland Confidential Morbidity Report (DHMH 1140); Safety Plan for Alleged Sexual Abuse; Memo from Director of Behavioral Health and Victim Services Re: Behavioral Health Referral Procedures and PREA Action Plan in all Facilities (Detention and Committed); and Victim Safety/Trauma Plan for

Alleged Sexual Abuse and Harassment. Interviews with medical and mental health practitioners verify that services are available to provide ongoing medical and mental health care for sexual abuse victims and abusers, even regarding abuse that did not occur in a facility.

Finding: The facility has shown compliance with this Standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? Yes No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? Yes No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? Yes No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? Yes No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? Yes No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?
 Yes No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation. Incident Reviews are to be done within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; and whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The team examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; and the team also assesses the adequacy of staffing levels in that area during different shifts. They assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. They report their findings, and any recommendations they have for improvement, to the facility head, and to the PREA Compliance Manager.

Analysis: Documentation reviewed for compliance with this Standard includes DJS Policy RF-701-18 (III M); FOP regarding Incident Reviews; and Appendix 10, Sexual Abuse Incident Team Review Form. The Incident Review completed regarding the one allegation received and investigated during the past 12 months was also reviewed. The Incident Review was completed even though the allegation was investigated and determined to be unfounded. Interviews with members of the Incident Review Team indicate an appreciation of the purpose of the reviews, and no barriers to continued compliance.

Finding: The facility has shown compliance with this Standard.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? Yes No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? Yes No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? Yes No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? Yes No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CYDC compiles accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions, and provides this to the State of Maryland at least annually. The facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Analysis: Documentation reviewed for compliance with this Standard includes: Survey of Sexual Victimization Forms 2017, DJS Policy OPS-900-15 Residential Facilities and Community Operations; DJS Policy RF-701-18 (III M 3); and the Incident Reporting Forms. The PC, PCM, and facility Superintendent verified and explained this process, describing a system with proper oversight and integrity to justify a high degree of confidence in the reliability of their data.

Finding: The facility has shown compliance with this Standard.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse Yes No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency reviews data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. Comparative data on sexual abuse allegations and findings is listed on the Maryland Department of Juvenile Services public website. The annual report includes a comparison of the current year's data and corrective actions to those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public, at least annually, through its website. The annual reports are approved by the agency head, as per protocol. When the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility, and the agency indicates the nature of material redacted.

Analysis: To show compliance with this Standard, the agency and facility provided DJS Policy RF-701-18 (III M, 4 and 5 e); DJS 2017 & 2018 Annual Reports; and the publications on the DJS Website. Interviews with administrators, and other data available through the audit process, provided evidence of compliance.

Finding: The facility has shown compliance with this Standard.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
 Yes No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? Yes No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? Yes No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policies and procedures indicate that the agency ensures that data collected pursuant to § 115.387 are securely retained for 10 years. Aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, are readily available to the public at least annually through its website. Annual Reports from 2014 through 2018 are posted.

Analysis: Documentation reviewed for compliance with this standard include DJS Policy RF-701-18 III M 3, 4, & 5, and Annual Reports located at: <https://djs.maryland.gov/Pages/PREA-Reports.aspx#annual>. Since this auditor has audited facilities agency-wide, the interviews and documentation relating to compliance with this Standard are numerous. It appears that the data at the facility level is consistent with the data collected by the agency, which has been appropriately aggregated into these publicly available reports.

Finding: The facility and agency have shown compliance with this Standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?
 Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency provided the Pre-Audit Questionnaire and supporting documentation more than 3 weeks in advance of the on-site audit, and it showed material evidence of PREA compliance, much of which has spanned over the course of several years. All facilities are current on their audits.

Analysis and Finding: The facility has shown compliance with this Standard.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued

in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The previous audit is posted at <http://www.djs.maryland.gov/Pages/PREA.aspx>.

Analysis and Finding: By consistently posting their prior audits, the agency has shown compliance with this Standard.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir

07-31-2019

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.