Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 08-02-2019

Auditor Information

Name: David "Will" Weir, MCJ	**Email:** Will@preaamerica.com
Company Name: PREA America	
Mailing Address: POB 1473	**City, State, Zip:** Raton, NM 87740
Telephone: 405-945-1951	**Date of Facility Visit:** 6-21-2019

Agency Information

Name of Agency Maryland Department of Juvenile Services		**Governing Authority or Parent Agency** *(If Applicable)*	
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:	Savage Mountain Youth Center			
Physical Address:	164 Freedom Lane; Lonaconing, Maryland 21539			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	410-778-6444			
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other
Facility Mission: .				
Facility Website with PREA Information:	https://djs.maryland.gov/Pages/PREA.aspx			
Is this facility accredited by any other organization?	☐ Yes ☒ No			

Facility Administrator/Superintendent

Name:	Walter Alston	**Title:**	Superintendent
Email:	Walter.Alston@maryland.gov	**Telephone:**	(301) 463-2244, (301) 463-5699, (301) 463-3015

Facility PREA Compliance Manager

Name:	David E. Green	**Title:**	Assistant Superintendent
Email:	David.Green@maryland.gov	**Telephone:**	(301) 463-2244, (301) 463-5699, (301) 463-3015

Facility Health Service Administrator

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

Facility Characteristics		
Designated Facility Capacity: 24	**Current Population of Facility:** 7	
Number of residents admitted to facility during the past 12 months		8
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		8
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		8
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	13-19	
Average length of stay or time under supervision:		94 days
Facility Security Level:		Hardware Secured
Resident Custody Levels:		Committed
Number of staff currently employed by the facility who may have contact with residents:		45
Number of staff hired by the facility during the past 12 months who may have contact with residents:		15
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		4

Physical Plant	
Number of Buildings: 11	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	3
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.):

There are 184 operational cameras. They are located in the school, the administration buildings, supply areas, medical building, dorms, offices, recreational areas, visitation, intake rooms, hallways, kitchen, dining, maintenance, entrances, control areas, and around the perimeter.

Medical	
Type of Medical Facility:	Registered Nurse Charge is on grounds Monday - Friday, 8 hours a day
Forensic sexual assault medical exams are conducted at:	Western Maryland Regional Medical Center

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	40
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 Savage Mountain Youth Center (SMYC). Introductory communication with the PREA Coordinator took place shortly after scheduling the on-site audit dates, including discussion of 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 21. 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 colored 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 04-09-19. The date of the email was used to verify the minimum posting requirement of six weeks, along with observations of the postings during the physical plant tour.

During the Pre-Audit Phase, an extensive desk audit 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 to understand 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 the initial background check, the child abuse registry check, and the 5-year recheck requirement, reviews were conducted of files on 6 randomly selected staff, and of files on 2 contractors and volunteers. PREA education and PREA Screening documentation were reviewed for all residents admitted during the past 12 months. 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 confirming current population of 7; agenda and logistics review; discussion of mandatory reporting; and clarification of 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. The supervision and movement of staff and residents were observed, and casual conversation was

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, including third-party reporting postings, were checked. 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.

All 7 residents at the facility were interviewed. Random Staff interviews were made to include gender, shift, and posting diversity. Interviews were held in a conversational manner, to gain the confidence of those interviewed and to put them at ease, so that the audit team could better comprehend their understanding of PREA and of the practices of the facility. A total of 29 unique interviews were conducted for this audit, not counting the interviews with advocates to verify services in the community. This does include 6 Agency Staff: Contract Monitor, Agency Head Designee, Agency PREA Coordinator, Agency Human Resources, Investigator, and Deputy Inspector General. Some of these interviews were conducted by phone prior to the on-site audit. 12 Random Staff and 11 Specialized Staff interviews were also conducted. Since Specialized Staff perform multiple duties, each was interviewed according to the duties they perform. Facility interviews included the Superintendent, 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, attended by 7 administrators, 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 the 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. Many strengths were observed, such as the availability of mental health professionals to the residents, the efficiency of the staff, and their ability to work as a team, as demonstrated in the way the audit process was effectively facilitated. Only a couple of issues were identified that day, upon which the audit team requested more verification of compliance. There was a blind spot in the equipment closet located in the gym, but this was resolved the same day as the on-site audit, by adding shelving on the right side of the closet. A picture was taken and emailed on 6/21/19. The audit team reviewed all assessments and re-assessments regarding risk for sexual abusiveness and victimization. In addition to these, the facility provides an array of screenings and evaluations of residents, and it conducts meetings regarding their needs. The audit team asked whether they are sure all available information regarding risk factors is included in the screenings for risk of sexual victimization. The agency and facility tackled this issue by conducting re-assessments on all the youth, along with behavioral health screening forms identifying youth risk factors. The PREA Coordinator described the results this way, “Risk factors were identified and housing and programming placements are made accordingly. When applicable, the facility shares the information immediately and has follow up weekly treatment team and management meetings as well as department head meetings every two weeks.”

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.

Lonaconing Forestry Camp for Boys opened in December, 1957, and was renamed Savage Mountain Youth Center (SMYC) in 1977. After closing in 1999, SMYC reopened in 2001. Then, for the majority of 2018, SMYC was temporarily closed due to the major construction / physical plant upgrades and renovations being completed to make the facility a secure treatment facility.

Construction /Renovations included:

- Removal of all trees within the facility perimeter and outside of the fence area within 60 feet. This included the Climbing Tower/Zip Line.
- Two holding ponds had to be dug.
- Perimeter Fencing all around the facility to ensure safety and security. A few buildings (Supply House, Old Education Building, and Maintenance) will remain outside of the perimeter fencing.
- The newly constructed Gatehouse Building features a 360-degree view of the three main entrances into the facility. The Master Control Center has (4) 32" tv monitors, with facility cameras posted on them at all times. There are two control panels. One panel controls the Door Entrances into the Gatehouse. The other panel controls the exterior fencing and Gate Entrances into the facility. The basement has a staff locker room, a meeting room, and a bathroom/shower.
- The newly constructed, 12-section, modular trailers to provide educational services for Maryland Department of Education (MSDE) were ordered, delivered, and set.
- Renovations to the old "lower educational building" were developed as the new Administration and Behavioral Health Building.

SMYC operates under the umbrella of the Department of Juvenile Services, providing services as a hardware-secure treatment center for male youth. On December 21, 2018, DJS re-opened SMYC and accepted the first two admissions for the re-opening of the facility. The facility has a school with several classrooms, with Tech and Media centers. There are several storage sheds and storage containers which are secured. The campus includes A Gym, Dorm, Maintenance, Pump House, Behavioral Health, Administration, Kitchen, and Dining Hall.

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: 4

Standard 115.316: Residents with disabilities and residents who are limited English proficient; Standard 115.331: Employee training; Standard 115.317: Hiring and promotion decisions; and Standard 115.367: Agency protection against retaliation.

Number of Standards Met: 39

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

SMYC did not require 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.

SMYC has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and it 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 Assistant Superintendent as the PREA Compliance Manager.

Analysis: Documentation reviewed for compliance with this Standard includes: Facility Operating Procedure; Agency and Facility Organizational Charts; Maryland Department of Juvenile Services (DJS) Policy: Elimination and Reporting of Sexual Abuse and Harassment-PREA Juvenile Facility Standards Compliance RF-701-18, and the associated Procedures; Memos of the appointment of the Agency-Wide PREA Coordinator; and Memo appointing the PREA Compliance Manager, and list of duties. In addition, interviews conducted with the PC, PC's supervisor, PCM, PCM's supervisor, and

many other interviews conducted throughout this audit, 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

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When DJS contracts for the confinement of its residents with private agencies, or 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); Natchez Trace (UHS of Delaware, Inc., d/b/a KidLink Network); 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

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☒ **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.

SMYC 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 12. The average daily number of residents on which the staffing plan was predicated is 24. 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. SMYC maintains the required minimum staffing ratios of 1:8 during resident waking hours and 1:16 during resident sleeping hours. It is clear that the facility often exceeds these ratios since reopening. At least once every year, the 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: Documentation reviewed for compliance with this Standard includes: Facility Staff-to-Youth ratios from Direct Care Procedure Appendix 2 for years 2017-2019; Facility Vulnerability Assessment for years 2017-2019; FOP: Exigent Circumstances for Cross-Gender Searches; Blind Spots Evaluation; Facility Staffing Plans 2017-2019; Quarterly Facility Surveillance Camera Listing 2018-2019; FOP for compliance with Department of Juvenile Services Policy RF-713-14; FOPs for Maintaining Ratios in Exigent Circumstances, Unannounced Rounds, Security, and Control; and 2017-2019 Staff Schedules. Documentation appears to be consistent with interviews, which were conducted of residents, of staff, and of supervisors, who were asked about supervision practices regarding residents. Documentation and interviews indicated an understanding and practice of this Standard. During the Site Review, there was a blind spot identified in the equipment closet located in the gym. This was resolved the same day as the on-site audit by adding shelving on the right side of the closet.

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*)

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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. The facility also has policy consistent will 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 provided information indicated no instances of exigent circumstances resulting in cross-gender searches in the past year.

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 ß 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 include: 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. Interviews with staff and youth indicate a population well versed regarding de-escalation and skills-building. The residents are aware that staff are trying to hold them accountable, while increasing their coping skills and redirecting them in positive ways. Not only do disabled youth receive assistance needed due to their challenges, but all youth are helped to calm down with upset, and are spoken to calmly and with respect, and offered repeated reminders in ways that can help them break ineffective coping habits and regain self-control. They have access to assistance with the grievance system, mental health care, and daily medical services.

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; 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 facility has shown compliance with this Standard, and has exceeded the requirements.

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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SMYC was closed for the majority of 2018 due to the major construction and physical plant upgrades and renovations being completed. Construction /Renovations included:

- Removal of all trees within the facility perimeter and outside of the fence area, within 60 feet. This included the Climbing Tower/Zip Line.
- Two holding ponds had to be dug.
- Perimeter Fencing all around the facility to ensure safety and security. A few buildings (Supply House, Old Education Building, and Maintenance) will remain outside of the perimeter fencing.
- The newly constructed Gatehouse Building features a 360-degree view of the three main entrances into the facility. The Master Control Center has (4) 32" tv monitors, with facility cameras posted on them at all times. There are two control panels. One panel controls the Door Entrances into the Gatehouse. The other panel controls the exterior fencing and Gate Entrances into the facility. The basement has a staff locker room, a meeting room, and a bathroom/shower.
- The newly constructed 12-section modular trailers, in which to provide educational services for MSDE were ordered, delivered, and set.
- Renovations to the old "lower educational building" were developed as the new Administration and Behavioral Health Building.

Analysis: Documentation reviewed for compliance with this Standard includes: Photos, layouts, schematics, and aerial views of facility buildings; DJS Policy RF-701-18 III (I); Camera List; and Quarterly Video Review. Interviews conducted, the site review, and the 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 the 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. These are called Sexual Assault Responders/Support Staff (SARS). Interviews with the SANE nurse, and documentation provided by the facility, indicate that youth who need forensic exams will be taken to Western Maryland Regional Medical Center.

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, Mental Health Licenses List and Certificate, 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. The content of information received by the audit team during interviews with random staff, the SANE Nurse, and the PREA Compliance Manager, were all consistent with understanding and complying with this Standard.

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. Even through the agency training covers more than the minimum required topics of this Standard, the facility goes further, documenting Muster Trainings that have often been provided daily regarding PREA related topics.

Analysis: Documentation reviewed for compliance with this Standard includes: Facility FOP mandating Muster Training at SMYC; and DJS policy (RF-701-18) requiring training agency-wide; Mandated Training Spreadsheet; Training Logs and documentation for 2 years, including months of recent Muster Training; 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, including activities; and training acknowledgments and test scores. Staff who had been randomly selected for interviews were questioned regarding the training they received. They verified that they had received all the training they were asked about, and they also demonstrated an understanding of the training during the interview.

Finding: The facility has shown compliance with this Standard, and significantly exceeded the minimum requirements.

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 all 40 volunteers/contractors understand the training they have received.

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; Facility Programing Chart; 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 a randomly selected contractor and volunteer, 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.

SMYC 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; 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 who have been at SMYC 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.

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 the 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.

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 19 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.

SMYC 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: Resident Screenings and Reassessments completed since the facility re-opened; FOP regarding Admissions and Orientation of Youth; DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities; DJS Policy RF-716-18 Classification of Youth in DJS Residential Facilities; DJS Facility Initial Reception/Referral Screening Tool (FIRRST); Housing Classification Assessment and Re-Assessment Forms; Bed Chart; and Facility Schematic. The facility provides an array of screenings and evaluations of residents beyond what is required by PREA, and it conducts meetings regarding the needs of residents. Medical and Mental Health reviewers sign off on every screening, often making notations. But this does not prove that all the risk factors known by medical and mental health practitioners have been made

available to affect the weight of the risk score. The audit team asked whether they are sure all available information regarding risk factors is included in the screenings for risk of sexual victimization. The agency and facility tackled this issue by conducting re-assessments on all the youth, along with behavioral health screening forms identifying youth risk factors. The PREA Coordinator described the results this way, “Risk factors were identified and housing and programming placements are made accordingly. When applicable, the facility shares the information immediately and has follow up weekly treatment team and management meetings as well as department head meetings every two weeks.”

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.

SMYC uses information from the risk screening required by ß115.341 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: Resident Screenings and Re-assessments completed since the facility re-opened; FOP regarding Admissions and Orientation of Youth; DJS Policy RF-715-18 Admissions and Orientation of Youth in DJS Facilities; DJS

Policy RF-716-18 Classification of Youth in DJS Residential Facilities; DJS Facility Initial Reception/Referral Screening Tool (FIRRST); Housing Classification Assessment and Re-Assessment Forms; Bed Chart; and Facility Schematic; FOP Housing Plan for At-Risk Youth; FOPs regarding Reception, Service Team, Transfers, and Classification of Youth; Floor Plan; and Housing Bed Charts. Interviews indicate that safety, including sexual safety, is paramount in the decisions being made regarding the youth in care, and that all provisions of this Standard are taken seriously in every case.

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.

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 staff training curricula. Interviews of staff and residents verify that they are trained about reporting, and can, in reality, make reports, although they have not had to make any. The Site Review verified that different ways to report are made available.

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.

SMYC 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 as signage observed during the Site Review, combine to indicate that the grievance system is in working order, although there have been no known emergency grievances, and although all sexual abuse and sexual harassment allegations are sent to OIG, CPS, and/or law enforcement for investigation.

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 assessible 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 Western Maryland Regional Medical Center, Cumberland, MD. Advocacy for survivors is available from the Family Crisis Resource Center in Cumberland, through their "Response Team". Advocacy is coordinated throughout the state by the Maryland Coalition Against Sexual Assault (MCASA). These resources have been verified by the audit team.

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; and documented attempts to develop additional advocacy MOU. Interviews indicate that, despite delays regarding establishing MOUs beyond the one with MCASA, residents already have full access to outside confidential support services and legal representation.

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 the number of the Office of the Inspector General (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.

SMYC 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 SMYC 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 have been no times the agency or 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.

SMYC 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.

SMYC 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; and staff training materials. During interviews, staff and administrators demonstrated an understanding of these duties.

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.

SMYC 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 (CRP). 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 audit team reviewed documentation completed by the OIG regarding incidents that occurred in other agency facilities. Although no incidents of retaliation are known to have occurred in the past 12 months, the facility and OIG Youth Advocates each demonstrate that they employ duplicate protection measures and document these weekly, rather than monthly as required by the Standard. This is a Standard that has been found to exceed the minimum requirements of this Standard agency wide. Since administrators, as well as staff, at SMYC are so well versed regarding their requirements to respond to allegations of sexual abuse, including watching for and avoiding retaliation, and monitoring for retaliation, they have proven that they also exceed the minimum requirements of this Standard, despite not having incidents to monitor for in the past 12 months.

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 SMYC 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 SMYC 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 showing 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 they 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 anyone to avoid their education, nor deny them medical care, nor 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 includes 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 regarding investigations conducted at other agency facilities. 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 have been no investigations of alleged sexual abuse or harassment. Compliance with this standard was verified through interviews, review of policy, and a review of investigative documentation of investigations completed at other agency facilities, including the notifications made for the investigations completed in the past 12 months. These investigations are relevant since OIG does all agency administrative sexual abuse and sexual harassment investigations for the DJS.

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.

SMYC 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 facility staff have been found to have violated agency sexual abuse or sexual harassment policies.

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 the 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.

SMYC 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 (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 include 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 supervisors and other administrators indicate compliance with this Standard. In the past 12 months, there have been no allegations of resident-on-resident sexual abuse or sexual harassment. Files were reviewed agency-wide, and the agency and facility appear to be fully compliant with the minimum 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 SMYC who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 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 ß 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 screening documentation, provided verification to the auditor 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.

SMYC 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.

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; Coordinated Response Plan (CRP); Email confirming Free Medical Exam, 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). Interviews and CRP indicate Western Maryland Regional Medical Center provides emergency care and mental health care is available 24/7 by on-call providers.

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.

SMYC offers medical and mental health evaluation and, as appropriate, and 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. Documents were furnished that provide examples of this care being provided.

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. However, the facility FOP states that the facility will ordinarily do these within 7 days. 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: Sexual Assault Incident Review Team Memo, DJS Policy RF-701-18 III M. FOP Incident Review, Appendix 10, Sexual Abuse Incident Team Review Form. Interviews with members of the Incident Review Team indicate an appreciation of the purpose of the reviews, and they indicate 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.

SMYC 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, 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 for the agency as a whole. Comparative data on sexual abuse allegations and findings are 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: Documentation reviewed for compliance with this Standard includes: Survey of Sexual Victimization, 2017: Substantiated Incident Form (regarding a different facility); Survey of Sexual Victimization, 2017: State Juvenile Systems Summary Form; DJS Policy RF-701-18 III M (4 and 5 e) DJS 2017-18 Annual Reports; and DJS Website. The policies and published reports are consistent with this Standard. Information from interviews and other sources reviewed do not contradict the data in the data in the reports.

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

from 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 includes 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, which appears to have 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 08-02-2019

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.