Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report October 16, 2018

Auditor Information

Name: Sharon G. Robertson	**Email:** sharongr@bellsouth.net
Company Name: PREA Auditors of America, LLC	
Mailing Address: P.O. Box 10	**City, State, Zip:** Linville Falls, NC 28647
Telephone: (828) 765-8180	**Date of Facility Visit:** July 16-17, 2018

Agency Information

Name of Agency Alaska Division of Juvenile Justice		**Governing Authority or Parent Agency** *(If Applicable)* Alaska Department of Health and Social Services	
Physical Address: 240 Main Street, Ste 700		**City, State, Zip:** Juneau, AK 99801	
Mailing Address: P.O. Box 110635		**City, State, Zip:** Juneau, AK 99811	
Telephone: (907) 465-3312		**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:
Our mission is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Agency Website with PREA Information:
http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx

Agency Chief Executive Officer

Name: Tracy Dompeling	**Title:** Division Director
Email: tracy.dompeling@alaska.gov	**Telephone:** (907) 465-2212

Agency-Wide PREA Coordinator

Name: Matt Davidson	**Title:** PREA Coordinator
Email: matt.davidson@alaska.gov	**Telephone:** (907) 465-8644
PREA Coordinator Reports to: Barb Murry, Deputy Director	**Number of Compliance Managers who report to the PREA Coordinator** 7

Facility Information

Name of Facility:	**KENAI PENINSULA YOUTH FACILITY**		
Physical Address:	405 Marathon Road, Kenai, AK 99611		
Mailing Address (if different than above):	same as above		
Telephone Number:	(907) 335-3100		
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Facility Type:	☒ Detention	☐ Correction	☐ Intake	☐ Other

Facility Mission: Click or tap here to enter text.

Facility Website with PREA Information: http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx

Is this facility accredited by any other organization? ☒ Yes ☐ No Performance Based Standards (PbS)

Facility Administrator/Superintendent

Name:	Steve Kiefer	**Title:**	Superintendent I
Email:	steve.kiefer@alaska.gov	**Telephone:**	(907) 335-3120

Facility PREA Compliance Manager

Name:	Steve Kiefer	**Title:**	Superintendent I
Email:	steve.kiefer@alaska.gov	**Telephone:**	(907) 335-3120

Facility Health Service Administrator

Name:	Ella May Cooper Waldron	**Title:**	Nurse II
Email:	ellamay.cooper.waldron@alaska.gov	**Telephone:**	(907) 335-3104

Facility Characteristics

Designated Facility Capacity:	10 Co-Ed	**Current Population of Facility:**	5 males

Number of residents admitted to facility during the past 12 months	61
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	47
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	58
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	12 – 19 years old
Average length of stay or time under supervision:	33

Facility Security Level:	Medium
Resident Custody Levels:	Medium
Number of staff currently employed by the facility who may have contact with residents:	20
Number of staff hired by the facility during the past 12 months who may have contact with residents:	2
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 10
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	1
Number of Segregation Cells (Administrative and Disciplinary:	0

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

The facility has a video monitoring system, which includes 34 high definition video cameras that are recordable that monitors the interior and exterior of the secured detention facility. The CCTV system, installed in November of 2003, was upgraded in November 2016. The video system is actively monitored 24/7 via screens by the Unit Supervisor ("JJUS") and the Superintendent in the staff station and control room.

Medical

Type of Medical Facility:	8 hours – Nurse Clinic
Forensic sexual assault medical exams are conducted at:	Emergency Room at Central Peninsula Hospital Soldotna, Alaska

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	14
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of the Kenai Peninsula Youth Facility ("KPYF") located in Kenai, Alaska, was conducted on July 16-17, 2018 by Sharon G. Robertson from Linville Falls, North Carolina, a U.S. Department of Justice ("DOJ") Certified PREA Auditor for Juvenile Facilities, working as a contractor for PREA Auditors of America, LLC. This is KPYF's second PREA audit since the implementation of the PREA standards on August 20, 2013. KPYF's first PREA audit was conducted in February 2015. Audit Notices were posted throughout the facility in all areas where residents, staff, volunteers, contractors, and visitors to the facility could be viewed by May 18, 2018, more than seven weeks prior to the on-site audit review and photographic evidence was submitted to the Auditor demonstrating the timely posting of the Notices. The facility was requested and agreed to keep all Notices posted for three weeks after the on-site audit review. Posted Audit Notices were observed by the Auditor throughout the facility during the on-site audit. As of the date of this report, the Auditor has not received any correspondence at the PREA Auditors of America Post Office box.

KPYF staff was requested to complete the *Pre-Audit Questionnaire* and it was provided to the Auditor, along with supporting documents in the weeks preceding the on-site review portion of the audit. The facility provided three updates to their initial response to the *Pre-Audit Questionnaire*. Pre-audit preparation included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed and revised *Pre-Audit Questionnaire*. The documentation reviewed included Alaska Division of Juvenile Justice ("DJJ") agency policies, including DJJ PREA policies as set forth in L-100, *Prison Rape Elimination Act (PREA)*, effective March 12, 2015, hereinafter referred to in the audit report as "DJJ P&P L-100 (relevant subsection)", other DJJ policies and procedures, forms, contracts, education materials, training certification, organizational charts, posters, brochures, and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The review prompted a series of questions that were reduced in writing and submitted to the DJJ PREA Coordinator and KPYF PREA Compliance Manger in the form of three *Deficiencies Lists* to which responses were requested, and answered by the PREA Coordinator and KPYF staff in the weeks before the on-site portion of the audit. The same were reviewed by the Auditor prior to the on-site review. Days prior to the on-site audit the Auditor was provided a roster of staff and residents. On the first day of the on-site audit, the Auditor provided KPYF staff the names of the random staff and residents selected by the Auditor for interview during the on-site review.

On the morning of July 16, 2018, the Auditor conducted an entrance conference with the facility Superintendent, who is also the PREA Compliance Manager, and the Juvenile Justice Unit Supervisor ("JJUS"). The discussion focused on the purpose of the PREA audit, an overview of the PREA process, identification of specialized staff, and the audit schedule.

Following the entrance meeting, the Auditor toured the physical plant escorted by the Superintendent. KPYF consists of one building. The tour started in the wing housing the probation offices, Superintendent's office, staff lounge, and conference room where residents are escorted into by staff for video conferencing. The Auditor then toured the facility's exterior, facility's entrance where a PREA Incident box is located and a locked PREA box; classroom; dayroom and living room area where the staff desk station is located, PREA hotline telephone, locked grievance box and PREA envelope; the resident's wing containing 10 single cells, including one cell with observation camera, and separate single shower; multipurpose room with windows used for group meetings, library and where meals are served; storage area with posted notice that residents are not allowed; kitchen area where meals are delivered and residents are assigned KP duty supervised by staff; storage area with posted notice residents are not allowed; admissions area that includes an area allowing residents to disrobe out of camera range and camera pointed at staff all time, and overflow cell; vehicle bay; and control room with the bank of video monitors showing cameras with blacked out areas for toilet use.

During the tour of the physical plant, the Auditor spoke informally with staff and residents and paid particular attention to the video monitoring capabilities; mirror locations; posted Audit Notices; location of PREA posters and other PREA information; location of locked PREA boxes; location of locked grievance boxes; location of the telephones for residents; and bathroom and shower facilities. The Auditor also reviewed the Center Duty Officer Log Book. After the tour of the physical building the Auditor began interviewing random staff from all three shifts and specialized staff, contractors and volunteers, interviewed all residents, and conducted file review for the remainder of the day and continued on throughout the second day on July 17, 2018.

On the first day at the start of on-site audit, there were five male residents housed in the co-ed Detention Center, and by day's end one of the residents was released. The Auditor interviewed all the residents housed in the Detention Center during the first day of the on-site audit. Residents were interviewed using the recommended DOJ protocols that question their general and specific knowledge of a variety of PREA protections and reporting mechanisms available to residents to report abuse or harassment. On the dates of the on-site audit, there were no residents being housed with physical disabilities; who were deaf, blind or hard of hearing; who have Limited English Proficiency; who identified as having cognitive disability; who have identified as LGBTQQI; or had reported sexual abuse to staff. KPYF does not utilize isolation and there were no residents housed in isolation or who had previously been housed in isolation at the time of the on-site audit. The Auditor reviewed the resident PREA education materials and methods of reporting while on-site. Residents view the PREA video during intake/admissions, and it was viewed by the Auditor in its entirety.

A total of 17 agency and facility staff were interviewed during the on-site audit. This includes 9 Juvenile Justice Officers ("JJO") from the Grave Shift (Midnight-0800), Day Shift (0800-1600), and Swing Shift (1600-Midnight); and specialty staff including facility Superintendent/PREA Compliance Manager, medical, mental health, staff who conduct intake and risk screening, intermediate and higher level staff known as JJO III and Shift Supervisors, first responders, education staff, staff who supervise residents in isolation, member of the sexual assault incident review team, and staff who monitors retaliation. The Auditor spoke with the facility nurse and mental health staff during the on-site audit. One contractor and two volunteers were interviewed by the Auditor. All staff, contractors and volunteers were interviewed using the DOJ protocols that provides information regarding their PREA training, overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to staff and residents, the facility's response protocols when a resident alleges abuse, first responder duties, data collection processes, and other pertinent PREA requirements. The Auditor interviewed DJJ PREA Coordinator on July 11, 2018, at his offices in Juneau, Alaska, and the DJJ Director was interviewed by telephone on August 24, 2018.

The Auditor reviewed contractor and volunteer files containing their training records. As explained more fully in the Summary of Audit Findings, the Auditor was unable to personally review personnel files due to Alaska state laws and provided the names of 9 staff members to determine compliance with training mandates and background check procedures. The files for five residents currently being held in the facility were reviewed by the Auditor to evaluate the screening and intake procedure, resident education, and other general program areas.

The Auditor was provided private areas utilizing several areas of the facility from which to work and conduct confidential staff and resident interviews to speak privately and confidentially. Resident files, which also include the resident's medical files, were reviewed privately in the classroom by the Auditor.

The DJJ website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx provides an email address and telephone number for filing PREA reports. The Auditor sent an email to the DJJ PREA email address and received written acknowledgement that they accept reports of sexual abuse and sexual harassment, including anonymous and third party reports, and would initiate the PREA policy reporting procedures at the facility where the incident occurred with the PREA Compliance Manager to begin the PREA response checklist and contacting law enforcement. The Auditor also called the PREA hotline and confirmed that the caller can leave a voice message on the PREA hotline. Both the email and telephone hotline voice messages are monitored by the DJJ PREA office in Juneau, Alaska.

The Auditor also spoke by telephone with the Executive Director for The LeeShore Center in Kenai, Alaska to discuss and confirm the agreement in place with KPYF to provide rape crisis intervention services, forensic medical exams by SANE/SART medical staff, assistance in the development of treatment plans, and providing outside emotional support to victims and rape advocacy services.

The Auditor was greeted and treated with hospitality and professionalism by all staff during the on-site visit. Residents and staff were made readily available to the Auditor at all times for formal and informal interviews. The Auditor was provided with unimpeded access to all parts of the facility and access to all records during the on-site review.

The Auditor conducted an exit conference with DJJ PREA Coordinator (via telephone) and the facility Superintendent/PREA Compliance Manager. The Auditor thanked the staff for their cooperation and openness during the pre-audit process and on-site review. Administration and leadership were very open and receptive during the discussion of the few areas where PREA compliance needed to be strengthened.

Facility Characteristics

The Alaska Department of Health and Social Services, Division of Juvenile Justice operates the Kenai Peninsula Youth Facility, a 10-bed co-ed youth facility located at 405 Marathon Road in Kenai, Alaska, which opened its doors in September 2003. KPYF is a State operated facility which houses juvenile offenders who are being held pending a court advisement hearing, adjudication, trial, disposition, placement or classification to a treatment facility. The facility's resident dayroom contained mosaics in each four corners depicting the metamorphism of a butterfly which the Superintendent stated exemplified the goals of KPYF staff in transforming the residents who enter their facility. The secure-setting of the facility is maintained 24-hours each day by trained professional staff members who provide safe and secure therapeutic supervision with the average length of stay of 33 days. KPYF has contracted for the preparation of meals off-site and delivered to the facility.

KPYF is housed in one building. All doors are locked and controlled by staff. Staffs are located at station desk in the housing area and control the resident's cell door. The facility has 20 staff that has contact with residents and 2 contracts with contractors who have contact with residents.

The KPYF co-ed facility has 10 single cells with each resident having their own toilet and sink, staff desk station, and a curtained shower area. Residents shower separately. Residents are provided with cards to place under their door to alert staff for bathroom privacy. Juvenile Justice Officers ("JJO") conduct observation rounds every 15 minutes. The locked grievance box and PREA box are located on the wall adjacent to the television with information about The LeeShore Center, PREA hotline phone number, and grievance forms are located in the dayroom/living room area. The medical and mental health offices are located in a hallway adjacent to the dayroom/living room. In the past 12 months, 61 residents were admitted into the facility, with 58 residents having a length of stay over 72 hours and 47 residents having a length of stay 10 days or more.

The facility has a video monitoring system, which includes 34 high definition video cameras that are recordable that monitors the interior and exterior of the secured detention facility. The CCTV system, installed in November of 2003, was upgraded in November 2016. The video system is actively monitored 24/7 via screens by the Unit Supervisor ("JJUS") and the Superintendent in the staff station and control room and the Superintendent's office.

The Division of Juvenile Justice (DJJ) has placed significant emphasis on the importance of identifying and addressing unique resident needs and individual mental and emotional health concerns. In support of these efforts, DJJ has incorporated a trauma-informed care perspective. Trauma-informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and

helps survivors rebuild a sense of control and empowerment. DJJ and KPYF also commits to the Restorative Justice Philosophy in the approach to justice focusing on the needs of the victims and the offenders, as well as the involved community. Offenders are encouraged to take responsibility for their actions, "to repair the harm they've done – by apologizing, returning stolen money, or community service." In addition, the restorative justice approach aims to help the offender to avoid future offenses. DJJ and KPYF also participate with Performance Based Standards (PbS) to measure facility documentation, progress and areas needing improvement. PbS balances the juvenile justice system's responsibility to protect the public by keeping youths in custody secured and providing appropriate rehabilitative services to prevent future crime. PbS guides operations so that youths are safe in the facilities and return to the community with the skills and resources to grow up to be successful citizens. PbS also encourages facilities and programs to work closely with communities, families and social supports to ensure youths' re-entry is a collaborative effort. PBS and KPYF are both working collaboratively to reduce isolation or confining youth to their rooms and utilize it when necessary to protect the youth from harming themselves or others.

Summary of Audit Findings

This is KPYF's second PREA audit since the implementation of the PREA standards on August 20, 2013. KPYF's first PREA audit was conducted in February 2015. There have been no major upgrades to the facility or technology since the last PREA Audit in 2015. The facility reported that 100% of the staff, contractors and volunteers have received training on sexual abuse and sexual harassment prevention, detection and response per agency policy and procedure. Staffing ratios are at least 1:8 security staff during waking hours 1:16 during sleeping hours, with many documented instances of higher staffing ratios. During the past 12 months, the facility reported there have been no deviations from the staffing plan. KPYF received one grievance alleging sexual harassment by other residents, which was reviewed by the Auditor. The Auditor reviewed all grievances filed with KPYF from January 2017 through July 14, 2018. During the past 12 months, the facility reported there have been no sexual abuse investigations.

DJJ policy C-2 Background Investigations for Employees, Volunteers and Others regulate who will handle and maintain confidential background checks and fingerprint results under Background Check File Maintenance. Subsection (a) and (b) states that certain person (or persons) within each region shall be designated as a background check records custodian who has the responsibility to maintain the background check filing cabinet, which is locked and kept in a secured location, and the confidentiality of the files within. As per Department of Public Safety and FBI rules, DJJ policy C-2, Subsection (c) states that handling and maintaining background checks and fingerprint results require that the designated records custodian(s) maintain a current APSIN (Alaska Public Safety Information Network) security clearance at all times.

In order to personally review employee, contractor, and volunteer completed background checks, the Auditor would have had to obtain certification from the Alaska Department of Public Safety as an APSIN user, which would have included a security check, fingerprinting, and the requisite security clearance training. As a result the Auditor was not able to physically review the personnel files containing the background checks for employees, volunteers and contractors. The Auditor provided the PREA Coordinator with a list of employees, contractors, and volunteers, and requested that a representative of the Department of Health and Social Services verify that completed background checks were conducted pursuant to DJJ policy and PREA Standard 115.317.

The Auditor received a notarized Affidavit from the APSIN user responsible for each KPYF's background checks confirming background checks have been completed and follow-up background checks will be conducted every five years on all employees, contractors, teachers, volunteers, and others who may have contact with juveniles.

Interviews and informal interaction with the residents reflected that they are aware of and understand the PREA protections, the agency's zero-tolerance policy, and ways to make reports. Residents review the (1) DJJ PREA Orientation Form; (2) *Break the Silence*: *A Guide to Reporting Sexual Abuse and Assault*; (3) how to avoid risky situations; (4) shown the DJJ PREA video presentation; and (5) provided with a copy of the Kenai Peninsula Youth

Facility Guide to Success handbook. Residents indicated they were aware of PREA posters located throughout the facility, and were able to articulate to the Auditor what they would do and who they would tell if they were sexually abused. Residents indicated to the Auditor they were safe at KPYF. The agency and facility provides the names and contact information for a multiple agencies and advocacy services for residents, staff and third-parties to report sexual abuse and sexual harassment in the resident handbook, parent handbook, and on their website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx.

All staff could articulate the meaning of the agency's zero-tolerance for sexual abuse and sexual harassment. All staff stated they have received initial, detailed PREA training and yearly in-service training. Staff was knowledgeable about their roles and responsibilities in the prevention, reporting, and first responder duties. The agency has developed a first responder protocol for staff, contractor, and volunteers to follow. The agency has also developed a written plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The agency and facility have complied with a majority of the data collection and review standards, and will need to make sure annual reviews are conducted and posted on the agency's website.

In summary, after reviewing all pertinent information, policies and procedures, documentation, and conducting the on-site audit tour, resident interviews, and staff interviews, the Auditor found that the agency leadership and facility leadership have made PREA compliance a priority and have devoted a significant amount of time and resources to policy development and education of residents. Discussions with agency leadership and facility management reinforced the agency's and facility's commitment to ensuring the safety of residents and staff at KPYF against sexual abuse and sexual harassment. There are few, minor areas of compliance noted in this interim report that will require strengthening through corrective action as detailed in the interim report.

The final status of standards that were exceeded, met, or not met is detailed below. There are a total of 43 standards, having between 1-10 subsections. To achieve compliance of any given standard, the facility must achieve 100% compliance with each and every subsection within the Standard as set forth in this report. The compliance performance is shown in this Interim 2018 PREA Audit Report dated August 19, 2018, and finally for the Final Audit Report issued October 16, 2018.

PREA Standards Compliance Overview – Interim Audit Report

Number of Standards Exceeded: 0

Number of Standards Met: 36

- §115.311; §115.312; §115.315; §115.317; §115.318
- §115.321;
- §115.331; §115.332; §115.334; §115.335
- §115.341; §115.342;
- §115.351; §115.353; §115.354;
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.366; §115.367; §115.368;
- §115.371; §115.372; §115.373;
- §115.376; §115.377; §115.378;
- §115.381; §115.382; §115.383;
- §115.386; §115.387;
- §115.401; §115.403;

Number of Standards Not Met: 7

- §115.313; §115.316;
- §115.322;
- §115.333;
- §115.352;
- §115.388; §115.389;

Total Standards: 43

Summary of Corrective Action Taken to Achieve Full Compliance

The Interim Audit Report, dated August 19, 2018, reflected that there were seven Standards that were in non-compliance at Kenai Peninsula Youth Facility. Therefore, a required corrective action period not to exceed 180 days began on August 19, 2018. The Auditor recommended corrective action for the agency and the facility which they agreed to and began immediate corrections of those Standards found to be in non-compliance. KPYF completed the required corrective actions requested by the Auditor to bring the facility into full compliance with the PREA Standards. Initial documentation of corrective action was received by the Auditor on August 22, 2018. Further evidence of corrective action was received by the Auditor on August 24, 27, and 30, September 24, and October 15, 2018. The Auditor reviewed the submitted documentation to determine if full compliance was achieved. KPYF complied with all requests from the Auditor. A summary of the evidentiary basis for determining full compliance is discussed within each standard that was originally noncompliant.

As a result of successful corrective action, the Auditor determined that Kenai Peninsula Youth Facility has achieved full compliance with the PREA Standards as of the date of this final report. The summary of compliance based upon this final report is found below.

PREA Standards Compliance Overview – Final Audit Report

Number of Standards Exceeded: 0

Number of Standards Met: 43

- §115.311; §115.312; §115.313; §115.315; §115.316; §115.317; §115.318;
- §115.321; §115.322;
- §115.331; §115.332; §115.333; §115.334; §115.335
- §115.341; §115.342;
- §115.351; §115.352; §115.353; §115.354;
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.366; §115.367; §115.368;
- §115.371; §115.372; §115.373;
- §115.376; §115.377; §115.378;
- §115.381; §115.382; §115.383;
- §115.386; §115.387; §115.388; §115.389;
- §115.401; §115.403;

Number of Standards Not Met: 0

Total Standards: 43

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*)

Evidence Reviewed (documents, interviews, site review):

1. Kenai Peninsula Youth Facility ("KPYF") Completed Pre-Audit Questionnaire ("PAQ")
2. Agency Organizational Chart and KPYF Organizational Chart
3. DJJ P&P L-100 Prison Rape Elimination Act (PREA), effective date March 12, 2015 ("DJJ P&P L-100")
4. DJJ P&P L-100 Procedure I.

5. DJJ website: http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
6. Interviews with the following:
    a. PREA Coordinator
    b. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): Alaska Division of Juvenile Justice ("DJJ") has a comprehensive policy on sexual abuse and sexual harassment contained in Section: Program and Services, Rights of Juveniles, Number L-100, entitled, *Prison Rape Elimination Act (PREA)*, effective March 12, 2015 ("DJJ P&P"). The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy details definitions that are compliant with the PREA definitions. The policy further outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment; and detailed employee corrective actions and disciplinary sanctions for conduct that meets the definition of sexual abuse and harassment. The agency's zero-tolerance policy is also set out in their website.

Subsection (b): The agency has designated Matt Davidson as the PREA Coordinator and reports directly to Barb Murray, the Deputy Director of Programs/Administration who reports directly to the Division Director of the Division of Juvenile Justice ("DJJ") under the Alaska Department of Health & Social Services. Mr. Davidson is part of the upper management team at DJJ. During the on-site audit, Mr. Davidson reported to the Auditor that he does have sufficient time and authority to develop, implement and oversee the agency's efforts to comply with the PREA Standards.

Subsection (c): The facility has designated Steve Kiefer as the PREA Compliance Manager. Mr. Kiefer is the Superintendent at KPYF and reports directly to Matt Davidson, DJJ PREA Coordinator. During the on-site audit, Mr. Kiefer reported to the Auditor that he does have sufficient time to develop, implement and oversee the agency's efforts to comply with PREA.

Compliance with this standard was determined through policy reviews and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. Interviews with the following:
    a. PREA Coordinator
    b. Agency Executive Director

Findings (By Subsection):

Subsection (a): The agency has not entered into any contract for the confinement of residents with private agencies or other entities, including government agencies.

Subsection (b): The agency has not entered into any contract for the confinement of residents with private agencies or other entities, including government agencies.

Compliance with this standard was determined through policy reviews and interviews with specialized staff.

Corrective Action: None.

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? ☒ Yes ☐ No

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? ☒ Yes ☐ No

- Does the facility ensure only security staff are included when calculating these ratios? ☒ Yes ☐ No

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedure IV, *et seq.*
3. South Central Region Facility Policy and Procedures C-3035SCR, Juvenile Justice Officer Unit Staff Work Schedules
4. South Central Region Facility Policy and Procedures C-3055SCR, Leave Administration
5. KPYF Policy No. C-200KPFY Annual Leave Forecasts
6. KPYF Policy No. H-206KPYF Detention Unit Resident Supervision
7. KPYF Staffing Schedule from July 3, 2017 through June 30, 2018
8. KPYF Unit Log documenting Resident Searches
9. Interviews with the following:
    a. Superintendent
    b. PREA Coordinator
    c. PREA Compliance Manager
    d. Immediate or Higher Level Facility Staff
    e. Agency Executive Director

Findings (By Subsection):

Subsection (a): Pursuant to DJJ policy the agency has developed a staffing plan for KPYF; however, it is a series of regional policies and procedures that constituted the KPYF staffing plan addressing these subsections which is not compliant with the National PREA Resource Center *Staffing Plan White Paper* requiring that the Staffing Plan be a written single document reflecting the appropriate objective analysis of the facility's staffing needs according to the requirements of this Standard. The facility reported in the PAQ the average daily number of residents was 6 youths. As of July 12, 2018, the first day of the on-site audit, there were 5 male residents housed and a total of 4 staff on Day Shift (8:00AM-4:00PM), 3 staff on Swing Shift (4:00PM-12:00AM), and 2 staff on Grave Shift (12:00AM-8:00AM), for a total of 9 staff on duty. The facility has a video monitoring system, which includes 34 high definition video cameras that are recordable that monitors the interior and exterior of the secured detention facility. The CCTV system, installed in November of 2003, was upgraded in November 2016. The video system is actively monitored 24/7 via screens by the Unit Supervisor ("JJUS") and the Superintendent in the staff station and control room. Interviews with the agency director, the PREA Coordinator, Superintendent/ PREA Compliance Manager confirmed compliance with PREA standards, and that safety and security procedures are the primary focus when considering staffing patterns and video monitoring.

Subsection (b): DJJ policy requires deviations to be justified and document the deviation from the plan by the Juvenile Justice Unit Supervisor (JJUS) in the Unit Log. The facility reported in the PAQ there have been no deviations to the staffing plan for the past 12 months.

Subsection (c): The facility reported on the PAQ they have maintained a minimum staffing ratio of 1:8 during resident waking hours and a minimum staffing ratio of 1:16 during resident sleeping hours, and there have been no deviations to the staffing ratio for the past 12 months. A review of the KPYF staffing schedule from July 3, 2017 through June 30, 2018 confirmed that the facility maintained a higher staffing ratio than required by this standard for waking and sleeping hours.

Subsection (d): DJJ P&P L-100 Procedure II(f), policy requires the staffing plan to be reviewed annually for the four required elements in this standard by the facility PREA Compliance Manager and PREA Coordinator. The Auditor was informed during the pre-audit and during interviews with the PREA Coordinator and PREA Compliance Manager that the yearly review of the facility staffing plan has not been done.

Subsection (e): DJJ policy states that unannounced rounds by intermediate-level or higher-level supervisor will occur on all shifts and be noted in the unit log as "unannounced PREA supervisory round" or similar. Staff are prohibited from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility. The Auditor was informed that the KPYF Superintendent conducts unannounced rounds for all three shifts. The Auditor was provided a random sample of the documented unannounced rounds conducted by the Superintendent during some of the shifts; however but not for all three shifts and not being conducted at random times. During the on-site audit, the Auditor was informed by the Superintendent that unannounced rounds are being conducted during all shifts by intermediate-level and higher-level supervisors.

Corrective Action:

1. KPYF must develop a staffing plan as set forth in the National PREA Resource Center *Staffing Plan White Paper*.
2. The PREA Coordinator and KPYF PREA Compliance Manager must conduct and document the annual review of the KPYF staffing plan pursuant to DJJ P&P L-100 Procedure II(c) and subsection (d) of this Standard, and provide documentation of this review to the Auditor.
3. Provide documentation to the Auditor showing weekly documented unannounced rounds for all three shifts for a six-week period.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation to evidence and demonstrate corrective action taken by DJJ and KPYF administration regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. 2018 Kenai Peninsula Youth Facility Staffing Plan, dated September 5, 2018
2. 2018 Kenai Peninsula Youth Facility Staffing Plan Review, dated September 18, 2018
3. KPYF unannounced rounds

The KPYF Superintendent and PREA Compliance Manager in collaboration with the DJJ PREA Coordinator met and reviewed the facility's staffing plan in accordance with subsection (d) of this Standard and DJJ P&P L-100 Procedure II(c) on September 18, 2018. The Auditor was also provided with documentation showing unannounced rounds were performed for all three shifts This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedure II, Facility Supervision and Monitoring, *et seq.*
3. DJJ P&P L-100 Procedure IV, Juvenile Privacy, *et seq*.
4. DJJ P&P H-104 Searches and Contraband, Procedure II Searching Juvenile (Searches of Person), *et seq.*
5. DJJ P&P H-104 Searches and Contraband, Procedure III, Searches of Transgender or Intersex Residents, General Provisions, *et seq.*
6. DJJ P&P H-104 Searches and Contraband Procedure X, Training and Quality Assurance, *et seq.*
7. KPYF Unit Log documenting Resident Searches
8. Interviews with the following:
    a. Random Staff
    b. Random Residents

Findings (By Subsection):

Subsection (a): DJJ P&P H-104 Procedure II(f) addresses resident body cavity searches which may be authorized by the Superintendent or designee and may only be performed after a Standard or Admission search has been conducted and when there is probable cause to believe that weapons or contraband will be found. The facility reported in the PAQ they do not conduct cross-gender strip searches or cross-gender visual body cavity searches of residents. As part of the pre-audit, the Auditor was provided random examples of KPYF Unit Log documenting resident searches. In the past 12 months, there has been no cross-gender strip or visual body cavity searches performed by staff or non-medical staff. Staff interviews confirmed staff do not conduct cross-gender strip searches or visual body cavity searches of residents.

Subsection (b): DJJ P&P H-104 Procedure II does not allow for cross-gender pat-down searches except in exigent circumstances only. The facility reported in the PAQ in the past 12 months there has been no cross-gender pat-down searches performed by staff. It appears from staff interviews that staff do not perform cross-gender pat-down searches.

Subsection (c): DJJ P&P H-104 Procedure II(a)(4) requires that staff document searches in the unit log or Incident Report as indicated by this policy, including the subject of the search, the reason for the search, and who conducted the search. Staff are also required to justify and document a cross-gender search in Juvenile Offender Management Information System ("JOMIS"), the on-line case management database, chronological note-type PREA.

Subsection (d): DJJ P&P L-100 Procedure IV(a) prohibits staff of the opposite gender from viewing residents when showering, performing bodily functions, and changing clothing except in exigent circumstances or when viewing is incidental to security or room checks. DJJ P&P L-100 Procedure IV(b) requires staff of the opposite gender to announce their presence, absent exigent circumstances or a security necessity, before entering an area where a resident is likely to be showering, performing bodily functions, or changing clothing. During the on-site audit, the Auditor observed staff of the opposite gender announcing cross-gender presence. KPYF provides each resident with a sign to slide underneath their door when they are using the bathroom. Residents shower in a single, private shower area allowing residents to shower in a private manner. Interviews with staff and residents indicated that staff of the opposite gender is making announcements upon entering the housing units.

Subsection (e): DJJ P&P H-104 Procedure III prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status, and will seek to determine the status by conversing 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. Staff interviews confirmed that they were aware of the policy prohibiting searches of transgender or intersex residents for the sole purpose of determining their genital status.

Subsection (f): DJJ P&P H-104 Procedure X states that all Juvenile Justice Officers (JJO) are trained in search methods and practices and that the JJUS is responsible for ensuring training is completed by JJOs assigned to the unit prior to conducting searches. Refresher training shall be provided on an annual basis. The facility reported in the PAQ that 100% of security staff have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Staff interviews indicated they have received specialized training on cross-gender pat-down searches and performing pat-down searches of transgender and intersex residents.

Compliance with this standard was determined through policy reviews and interviews with residents and staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 III. Training and Orientation (c) and (d)
3. Memorandum of Understanding ("MOU") between Language Interpreter Center and DJJ, effective June 30, 2015
4. Materials used for orientation, cartoons and acknowledgment
5. Interviews with the following:
    a. Agency Head
    b. Random Staff
    c. Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedure III. Training and Orientation (d) ensures that residents with disabilities and /or limited English proficiency, including those who are blind or visually impaired, have an equal opportunity to participate in or benefit from all aspects of the Agency's PREA protections. The policy ensures that written materials are provided in formats and through methods that ensure effective communication with residents with disabilities, including youths who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The policy does not address who the agency deals with residents who are deaf, hard of hearing, or hearing impaired. DJJ has entered into a MOU, effective June 30, 2015, with Language Interpreter Center, a program of the Alaska Institute for Justice, to provide qualified interpreters and/or translators on its statewide registry who are independent contractors. The MOU with Language Interpreter Center does not provide sign language interpreting services for the deaf/hearing impaired juveniles. At the time of the on-site audit, there were no residents housed at the facility who were limited English proficient or who had communication disabilities.

Subsection (b): DJJ P&P L-100 III. Training and Orientation (d) ensures that residents who are limited English proficient ("LEP") have access to all aspects of the facility's PREA protections, including steps to provide interpreters through the MOU with Language Interpreter Center, who can interpret effectively, accurately and impartially, any speech, pamphlet, poster, video, etc. to ensure the LEP resident is orientated to PREA. The policy does not address deaf or hard of hearing.

Subsection (c): DJJ P&P L-100 III. Training and Orientation (d)(3) prohibits the use of resident interpreters, resident readers, or other types of resident assistance except in limited circumstances as authorized by the policy and this Standard. The facility reported that in the past 12 months there have been no instances where resident interpreters, resident readers, or other types of resident assistants have been used. Interviews with staff members consistently revealed that resident interpreters are never used and staff could articulate why using resident interpreters is not considered a best practice.

Corrective Action:

DJJ will need to revised DJJ L-100 Procedures III(d) to include juveniles who are deaf or hard of hearing. DJJ must ensure that staff at all facilities are notified of the revision regarding residents who are deaf or hard of hearing. Documentation showing the revisions to this policy will be included as part of in-service training at each DJJ facility.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 22 and 24, 2018 to evidence and demonstrate corrective action taken by DJJ and KPYF administration regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. DJJ Policy & Procedure Change Log for DJJ P&P L-100, dated August 24, 2018
2. DJJ P&P L-100 Procedure III. Training and Orientation, *et. seq.*, dated August 24, 2018
3. DJJ Power Point *Prison Rape Elimination Act*

DJJ revised DJJ L-100 Procedures III(d) to include juveniles who are deaf or hard of hearing and instructed staff translation service or other professional to assist to contact RNR Interpreting and provided their contact information. KPYF also provided a copy of the DJJ PowerPoint allowing a resident who is deaf or hard of hearing an opportunity to read what is spoken on the DJJ PREA video. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P A-4, Reference Checks for Prospective Employees, Volunteers, and Contractors, *et seq.*,
3. Form A-4.A Volunteer Application
4. Form A-4.B DJJ Employment Reference Check
5. Form A-4.C PREA Institutional Employment Check
6. Form A-4.D SOA Authorization to Release Confidential Employee Records
7. Form A-4.E DJJ Non-Employee Reference Check
8. Attachment A to A-4: How to Access SOA Pre-Employment Certification
9. DJJ P&P C-2, Background Investigations for Employees, Volunteers, and Others, *et seq.*, effective March 12, 2015
10. Attachment A to C-2 – Quick Guide to Background Check Database Queries
11. Attachment B to C-2 – Guidelines for Withdrawing a Job Offer due to a Failed Background Check
12. Attachment C to C-2 – Assigning a Background Check Number
13. Attachment D to C-2 – Background Check Placer Sheet
14. Form C-2.A DJJ Background Check Release/Waiver
15. Form C-2.B DJJ PREA Employment Standards Disclosure
16. Form C-2.C DJJ Background Investigation Database Checklist
17. Form C-2.D DJJ Background Check Review / Recommendation Form
18. Form C-2.E Background Check File Log
19. Signed Affidavit from Superintendent Steven Kiefer
20. Interviews with the following:
    a. PREA Coordinator
    b. Superintendent

Findings (By Subsection):

Subsection (a): DJJ P&P C-2 policy states DJJ shall not hire or promote anyone who may have contact with residents and shall not enlist the services of any contractor who may have contact with residents with the prohibitions set forth in this standard. This was verified by the Auditor through a notarized Affidavit from the APSIN user responsible for each KPYF's background checks confirming background checks have been completed and follow-up background checks will be conducted every five years on all employees, contractors, teachers, volunteers, and others who may have contact with juveniles.

Subsection (b): DJJ P&P C-2 policy states DJJ will also 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.

Subsection (c): DJJ P&P C-2 states before hiring new employees who may have contact with residents, background checks will involve an examination of the following databases: Alaska Public Safety Information Network (APSIN) Alaska criminal, traffic, fish and wildlife violation, warrant and protective order history database maintained by Alaska Department of Public Safety; National Criminal Information Center (NCIC) maintained by the Federal Bureau of Investigation; National Sex Offender Public Website (NSOPW) sex offender database maintained by the U.S. Department of Justice; Sex Offender/Child Kidnapper Registration Central Registry (SOCKR) sex offender database maintained by Alaska Department of Public Safety; Juvenile Offender Management Information System (JOMIS) juvenile offender database maintained by Alaska Division of Juvenile Justice; Online Resources for Children of Alaska (ORCA) child abuse and neglect database maintained by the Alaska Office of Children's Services; and CourtView Alaska Court System records database.

The facility reported in the PDQ that in the past 12 months 2 persons were hired who had criminal background record checks conducted. The Auditor was provided with a copy of blank forms for applications requiring new hires to disclose sexual harassment or sexual abuse resigned during a pending investigation of alleged sexual abuse or sexual harassment. The Auditor received a notarized Affidavit from the APSIN user responsible for each KPYF's background checks confirming background checks have been completed and follow-up background checks will be conducted every five years on all employees, contractors, teachers, volunteers, and others who may have contact with juveniles.

Subsection (d): DJJ P&P C-2, Procedures (b) and (d) state before hiring new contractors or volunteers who may have contact with residents, DJJ shall perform background records check, consult any child abuse registry, and contact all prior institutional employers for information on allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse or sexual harassment. The Auditor received a notarized Affidavit from the APSIN user responsible for each KPYF's background checks confirming background checks have been completed and follow-up background checks will be conducted every five years on all employees, contractors, teachers, volunteers, and others who may have contact with juveniles. The facility reported in the PAQ that in the past 12 months no contracts for services where criminal background record checks were conducted on staff who might have contact with residents.

Subsection (e): DJJ P&P C-2 states DJJ will make its best effort to conduct criminal background record checks at least every five years of current employees, contractors and volunteers who may have contact with residents.

Subsection (f): DJJ P&P C-2 requires DJJ employees and volunteers to report to their supervisors when cited for a violation requiring a court appearance, served with a domestic violence or stalking protective order, or charged, arrested, or convicted of a misdemeanor or felony offense.

Subsection (g): DJJ P&P C-2 states that material omissions or misrepresentations by applicants or current employees, contractors, community partners or volunteers regarding background histories shall be grounds for disciplinary action, up to and including possible dismissal or termination of service.

Subsection (h): DJJ P&P C-2 states the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving current or former employees to any institution employer conducting a background check with a signed consent to release information form.

As part of the PAQ documentation, the Auditor was informed there are several collective bargaining agreements currently in effect which can be found at http://doa.alaska.gov/dop/LaborRelations/unionContracts. The Auditor verified with the DJJ Director that none of the collective bargaining agreements contain language prohibits the agency or facility from disciplining or firing staff.

The Auditor received a notarized Affidavit from the APSIN user responsible for each KPYF's background checks confirming background checks have been completed and follow-up background checks will be conducted every five years on all employees, contractors, teachers, volunteers, and others who may have contact with juveniles.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. Interviews with the following:
    a. Agency Head
    b. Facility Superintendent
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): The agency reported in the PAD they have not acquired any new facility or made a substantial expansion or modification to the existing facility.

Subsection (b): The agency reported in the PAD they have not acquired any new facility or made a substantial expansion or modification to the existing facility.

Compliance with this standard was determined through review of documentation and interviews with specialized staff.

Corrective Action: None.

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*)

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100, *et seq.*
3. DJJ P&P A-5, *et seq.*, Administrative Investigations of Staff Misconduct, effective January 9, 2015
4. Memorandum of Understanding (MOU) with The LeeShore Center, signed August 25, 2014
5. Memorandum of Understanding (MOU) with Kenai Police Department and Alaska Division of Juvenile Justice, Kenai Peninsula Youth Facility (KPYF).
6. Interviews with the following:
    a. PREA Coordinator
    b. Superintendent
    c. PREA Compliance Manager
    d. The LeeShore Center staff

Findings (By Subsection):

Subsection (a): The agency is not responsible for investigating allegation of sexual abuse. Pursuant to DJJ P&P A-5, KPYF conducts administrative investigations of staff sexual abuse and sexual harassment. According to the Superintendent and PREA Compliance Manager, KPYF will conduct preliminary administrative investigations only, and all criminal sexual abuse investigations for staff and residents are referred to the Kenai Police Department pursuant to the MOU for investigation.

Subsection (b): The DJJ protocol is adapted from the national protocol referenced in this standard.

Subsection (c): KPYF does not perform sexual assault medical forensic evaluations, and offers all residents who experience sexual abuse access to forensic medical examinations, at no cost, where evidentiary or medically appropriate, at the Emergency Room ("ER") at Central Peninsula Hospital in Soldotnay, AK by SAFE/SANE medical staff. KPYF first responders will stabilize the victim upon receiving a report alleging sexual abuse and/or assault, and use best efforts to preserve forensic evidence while assisting the victim. KPYF reported in the PAQ that there have been no forensic medical exams conducted or performed by SANEs/SAFEs staff or qualified medical practitioner within the past 12 months. The Auditor verified through telephone conversation with SANE/SAFE Nurse at Central Peninsula Hospital in Soldotnay, AK that they provide SANE/SAFE medical nurses, and physicians are available on-call if not in the ER at the time the resident is brought in. KPYF reported in the PAQ that there have been no forensic medical exams conducted or performed by SANEs/SAFEs staff or qualified medical practitioner within the past 12 months.

Subsection (d): KPYF utilizes victim advocates from The LeeShore Center pursuant to the MOU, which states that Lee Shore shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information and referral.

Subsection (e): As agreed to in the MOU, The LeeShore Center will support the victim through the forensic medical examination process and investigatory interviews to provide emotional support, crisis intervention, information, and referrals at the request and approval of the victim. During the telephone conversation with the Executive Director at The LeeShore Center, the Auditor was informed that The LeeShore Center will always have a victim crisis counselor during the time of the forensic exam, and will provide, in conjunction with the facility's mental health staff, victim advocacy services for the resident including short-term and long-term therapy.

Subsection (f): KPYF conducts administrative investigations and criminal investigations are conducted by Kenai Police Department pursuant to a MOU. The Superintendent/PREA Compliance Manager shall request that the Kenai Police Department conduct a criminal investigation follow the requirements as required by the PREA standard.

Subsection (h): KPYF utilizes advocates from The LeeShore Center.

Interviews with random staff indicated they were knowledgeable of the facility's protocols and procedures and had received training and annual refresher training regarding incident response.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100, *et seq.*
3. DJJ P&P H-100, *et seq.*, Incident Notification and Reporting, effective July 1, 2014
4. DJJ Form H-100.A Incident Report Form
5. DJJ Form L-100.A PREA Incident Checklist
6. DJJ Website: http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
7. Interviews with the following:
    a. Agency Head
    b. PREA Coordinator
    c. PREA Compliance Manager
    d. Superintendent

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 and H-100 ensures that administrative investigation is completed for all allegations of sexual abuse and sexual harassment, and a referral made for criminal investigations. The facility reported in the PAQ that in the past 12 months, no allegations of sexual abuse and sexual harassment were received resulting in completed administrative investigations or referred for criminal investigation.

Subsection (b): KPYF staff shall complete the DJJ H-100.A Incident Report Form and the DJJ Form L-100.A PREA Incident Checklist for all allegations of sexual abuse and sexual harassment and contact the Superintendent and the DJJ Deputy Director of Operations. As of the date of the audit, the agency has not published any policy on its website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx or made the policy available through other means as required by this subsection.

Subsection (c): The DJJ P&P L-100 Procedures VI states that the PREA Compliance Manger shall request local law enforcement agencies conduct criminal investigation, and that the staff assigned to monitor a criminal investigation will indicate in the incident report whether the law enforcement investigation supports a finding that a crime has occurred, the allegation is false, the evidence is inconclusive, or law enforcement declined to investigate. The staff monitoring the investigation will request the relevant information from the local law enforcement agency. As of the date of the audit, the agency's website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx does not provide any information describing who is responsible for conducting the administrative investigations and criminal investigations, including identifying who the local enforcement agency responsible for the criminal investigation for KPYF; and the responsibilities of both the agency and the investigation agency during the investigation process.

Corrective Action:

DJJ must develop and publish on its website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx the information as required by this Standard as set out in subsection (b) and (c) above.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 30, 2018 to evidence and demonstrate corrective action taken by DJJ administration regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx

DJJ revised its website to include language describing who is responsible for conducting the administrative investigations and criminal investigations. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures III. Training and Orientation
3. DJJ On-Line Moodle-based PREA Training Curriculum
4. KPYF Electronic Training Records
5. Interviews with the following:

a. Random Staff

Findings (By Subsection):

Subsection (a): DJJ policy states that all division staff, nurses, mental health clinicians, contract employees, and permanent school staff will receive the on-line Moodle-based PREA training during the first three months of assignment and a refresher training every two-years thereafter.

Subsection (b): DJJ policy states that training is tailored to the unique needs and attributes of juveniles and to the gender of the residents in the facility. Refresher training is provided every two-years thereafter; and in the years the individual does not receive refresher training, is provided information on current sexual abuse and sexual harassment policies. Policy also requires that staff will receive additional training if they are reassigned from a unit that houses only male juveniles to a unit that houses only female juveniles, or vice versa.

Subsection (c): DJJ policy requires during the first three months of assignment, refresher training every two-years thereafter, and in the years the individual does not receive refresher training, is provided information on current sexual abuse and sexual harassment policies. Policy further requires the statewide training coordinator to maintain electronic records that individuals understand the training they have received. The facility reported in the PAQ that 20 staff who have contact with residents were trained on the PREA requirements enumerated above and by DJJ policy; and 20 staff were trained or retrained on the PREA requirements since the last audit in 2015. The Auditor reviewed documentation confirming all staff have received the training as outlined above.

Subsection (d): DJJ policy further requires the statewide training coordinator to maintain electronic records that individuals understand the training they have received.

Interviews with all staff indicated they had received the initial during the first three months of their assignment; they have received refresher training every year thereafter; and they have been provided information on current sexual abuse and sexual harassment policies. All staff were able to articulate their duties as enumerated in subsection (a) of this Standard.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures III. Training and Orientation, *et seq.*
3. DJJ PREA Orientation for Volunteers, Contractors and Teachers PowerPoint
4. DJJ Form L-100.B PREA and Confidentiality Acknowledgment Form
5. Interviews with the following:
    a. Contractors
    b. Volunteers
    c. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): DJJ policy states that all contracted service providers, visitors, volunteers, temporary school staff and individuals who have business with or use the resources of a facility will sign the PREA and Confidentiality Acknowledgment Form L-100.B during their orientation to the facility. Facility managers may require training for individuals based on the services they provide and level of contact they have with juveniles. The facility reported in the PAQ that 2 volunteers and contractors who have contact with residents have been trained or retrained in the agency's policies and procedures regarding sexual abuse and sexual harassment prevent, detection, and response. Interview with one contractor and two volunteers indicate that they had received training and aware of the facility's zero-tolerance policy for sexual abuse and sexual harassment.

Subsection (b): Per policy, the level of training, including training on the agency's zero-tolerance policy, provided by the facility to contractors and volunteers is based on the services they provide and level of contact they have with juveniles. The Auditor was provided a copy of the DJJ PREA Orientation for Volunteers, Contractors and Teachers PowerPoint for review which covers the agency's zero tolerance policy for abuse and harassment; communicating effectively with LGBTQQI youth; the role in preventing, detecting, reporting, and responding to abuse; the dynamics of sexual abuse, signs a juvenile might be the victim of abuse; and how to prevent sexual abuse between juveniles and between juveniles and staff.

Subsection (c): Per policy, the facilities will retain copies of the signed PREA and Confidentiality Acknowledgment Form L-100.B, confirming understanding their PREA orientation. During the on-site audit, the Auditor reviewed five volunteer and contractor records documenting their initial PREA training and signed L-100.B forms.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures III. Training and Orientation, *et seq.*
3. Memorandum of Understanding ("MOU") between Language Interpreter Center and DJJ, effective June 30, 2015
4. KPYF PREA Orientation Form
5. DJJ PREA Education video
6. Break the Silence, A Guide to Reporting Sexual Abuse and Assault
7. KPYF Youth Handbook – *Kenai Youth Facility Guide to Success*, updated November 15, 2017
8. On-site Tour of facility
9. Review of resident files
10. Interviews with the following:
    a. Intake Staff
    b. Random Residents

Findings (By Subsection):

Subsection (a): DJJ L-100 Procedures III(c) requires that during the admissions orientation process, admissions staff provide residents with information explaining in an age appropriate fashion the division's zero tolerance policy regarding sexual abuse and sexual harassment, and how to report incidents or suspicions of sexual abuse or sexual

harassment. The facility reported in the PAQ that 61 residents were admitted in the past 12 months received this information.

Admissions orientation is conducted by any of the Juvenile Justice Officers ("JJO") on duty the day the resident arrives, usually within 24 hours of resident's arrival. During the interview with JJO III, the Auditor was informed that the first information they review with each new resident during orientation is the PREA Orientation Form and the resident will watch the PREA video shown in the dayroom. This information was also confirmed by the Auditor during interviews with random residents and review of five resident files.

Subsection (b): DJJ L-100 Procedures III(c) requires within 10 days of admission residents view the PREA education video with facility staff are available to answer questions. The JJUS is responsible for monitoring documentation of resident participation in these educations sessions. Documentation is made in the resident's file hard copy and/or JOMIS. This information was confirmed by the Auditor during interviews with residents and review of six random resident files. The facility reported in the PAQ that 61 residents admitted in the past 12 months received comprehensive age-appropriate education on their rights to be free from sexual abuse and sexual harassment, from retaliation for reporting such incidents, and on the division's policies and procedures for responding to such incidents within 10 days of intake. On the date of the on-site audit, all of the residents had received comprehensive age-appropriate PREA education within 10 days of intake.

Subsection (c): DJJ L-100 Procedures III(c) requires residents transferred to a different division facility shall view the PREA education video and orientation materials, and any resident returning to the same facility within 30 days of viewing the video are not required to view it again unless deemed appropriate by facility staff. The facility reported in the PAQ that all residents have received PREA training. This information was confirmed by the Auditor during the interview with the lead staff member ("JJO III") and a random review of six resident files.

Subsection (d): DJJ L-100 Procedures III(d) requires the facility to take appropriate steps to ensure that juveniles with disabilities or with limited English proficiency have an equal opportunity to participate in or benefit from all aspects of the division's efforts to prevent, detect and respond to sexual abuse and sexual harassment. In addition, each facility shall ensure that any written materials are provided in formats or through methods that ensure effective communication with juveniles with disabilities, limited reading skills, or who are blind or have low vision. If staff suspect a juvenile is having difficulty understanding or comprehending the PREA orientation or educational video, staff shall take steps to assist the juvenile's understanding, including: (a) reading aloud written material such as the PREA orientation brochure, PREA cartoons, or acknowledgement; (b) providing more detailed explanation of the concepts and materials; or (c) contacting a translation service or other professional to assist in the explanation. DJJ has entered into a MOU with Language Interpreter Center, effective June 30, 2015, to provide qualified interpreters and/or translators. DJJ policy does not address juveniles who are deaf or hard of hearing.

Subsection (e): DJJ policy requires documentation be made in the resident's file hard copy and/or JOMIS. This information was confirmed during interview with JJO III and the Auditor's review of six resident files.

Subsection (f): DJJ and KPYF ensure that educational materials are continuously and readily available and visible to residents about PREA through posters, the resident handbook, and other resources in other written formats. The Auditor observed during the tour of the facility the housing wing, school programming areas, library, attorney and parent visitation areas, and kitchen work areas have PREA informational posters. Residents are also provided information on their right to not be sexually abused or harassed and their right to report on page 6 in the KPYF resident handbook.

Interviews with random residents indicate they have been provided information on the facility's zero tolerance within hours of arrival; they have seen the posters posted in the facility; and they know how to make a report.

Corrective Action:

DJJ must ensure that they provide resident educations in formats accessible to all residents including those are deaf and hard of hearing. Documentation showing the revisions to this policy will be included as part of in-service training at each DJJ facility.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 22, 2018 to evidence and demonstrate corrective action taken by KPYF administration regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. DJJ PowerPoint *Prison Rape Elimination Act*

KPYF provided a copy of the DJJ PowerPoint allowing a resident who is deaf or hard of hearing an opportunity to read what is spoken on the DJJ PREA video. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures III, Training and Orientation, *et seq.*
3. Interviews with the following:
   a. PREA Coordinator
   b. PREA Compliance Manager
   c. Superintendent

Findings (By Subsection):

Subsection (a): The agency and the facility do not conduct sexual abuse investigations and refers all such investigations to the Alaska State Troopers or Kenai Police Department.

Subsection (b): The agency and the facility do not conduct sexual abuse investigations and refers all such investigations to the Alaska State Troopers or Kenai Police Department.

Subsection (c): The agency and the facility do not conduct sexual abuse investigations and refers all such investigations to the Alaska State Troopers or Kenai Police Department.

Subsection (d): The agency and the facility do not conduct sexual abuse investigations and refers all such investigations to the Alaska State Troopers or Kenai Police Department.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with the PREA Coordinator, the PREA Compliance Manager, and the Superintendent.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures III. Training and Orientation, *et seq.*
3. Interviews with the following:
    a. Medical Staff
    b. Mental Health Staff

Findings (By Subsection):

Subsection (a): DJJ policy states that all division staff, nurses, mental health clinicians, contract employees, and permanent school staff will receive the on-line Moodle-based PREA training during the first three months of assignment and a refresher training every two-years thereafter. The KPYF medical and mental health staff provided the Auditor with documentation showing additional specialized training they have received through state-wide training and continuing education related to sexual abuse and detection.

Subsection (b): The KPYF medical providers do not conduct forensic examinations of victims.

Subsection (c): DJJ policy further requires the statewide training coordinator to maintain electronic records that individuals understand the training they have received.

Subsection (d): DJJ policy states that all division staff, nurses, mental health clinicians, contract employees, and permanent school staff will receive the on-line Moodle-based PREA training during the first three months of assignment and a refresher training every two-years thereafter. During the on-site audit, the Auditor verified that the mental health care practitioner has received the training as required by DJJ policy and the standard.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-101 PREA Risk Screening, *et seq.*, effective January 9, 2015
3. Form L-101.A PREA Risk Screening
4. Random Resident Files
5. Interviews with the following:
    a. PREA Coordinator
    b. PREA Compliance Manager
    c. Risk Screening Staff
    d. Random Residents

Findings (By Subsection):

Subsection (a): DJJ P&P L-101 Procedure (a) requires screening within 72 hours of the resident's admission by completing the PREA Risk Screening Form L-101.A. At KPYF a JJO III is responsible for conducting risk screening at the facility. Interview with the JJO III indicate that the risk screening is typically done within the hours of the resident's arrival. DJJ P&P L-101 Procedure (b)(5) requires the unit supervisor to review a juvenile's risk level based on new risk related information or if a juvenile is involved in a PREA-related incident in the facility; and to document the review in a JOMIS chrono, note type "PREA." The facility reported in the PAQ that 58 residents entered the facility in the past 12 months whose length of stay in the facility was for 72 hours or more were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into KPYF. A review of all resident files confirmed that the resident was screened within 24 hours of arrival utilizing the information from the Risk Screening Form L-101.A.

Subsection (b): KPYF uses an objective behavioral screening instrument Risk Screening Form L-101.A.

Subsection (c): KPYF utilizes the Risk Screening Form L-101.A to ascertain information about all 11 enumerated items in this standard to determine proper housing, bed assignment, education, and other programs assignments with the goal of keeping residents at high risk of being sexually abused and sexually harassed separate from residents who are at high risk of being sexually abusive.

Subsection (d): DJJ P&P L-101 Procedure (b) policy ensures that the information be ascertained through conversation with the resident during the intake process and 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 files. Residents are not forced or disciplined for refusing to answer or for not disclosing complete information. Interviews with the JJO III indicate they are reviewing all of the information as outlined in this subsection during risk screening, and notify the shift supervisor or center duty officer if a screening score indicates a risk for victimization or sexually aggressive.

Subsection (e): DJJ P&P L-101 Procedure (b)(e) controls the dissemination of the information obtained in the screening instrument, and staff receive training on confidentiality and victim advocacy.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

Corrective Action: None.

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*)

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-101 PREA Risk Screening, *et seq.*, effective January 9, 2015
3. Form L-101.A PREA Risk Screening
4. Random Resident Files
5. Interviews with the following:
    a. Superintendent
    b. PREA Compliance Manager
    c. Risk Screening Staff
    d. Staff Who Supervise Residents in Isolation
    e. Random Residents

Findings (By Subsection):

Subsection (a): DJJ P&P L-101 Procedure (b)(e) requires the information obtained in the screening and intake process be used to make housing and other assignments with the goal of keeping residents safe and free from sexual abuse. Interviews with specialized staff indicate the information is being used to make decisions on resident housing and programming.

Subsection (b): While the facility uses isolation, DJJ P&P L-101 Procedure (b)(f) states that juveniles identified by screening as a risk of victimization may only be isolated from others as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and only until alternative means of keeping all juveniles safe can be

arranged. During the periods of protective separation due to risk, juveniles shall not be denied daily large-muscle exercise, educational or other services, shall receive daily visits by medical or mental health staff, and the unit supervisor will conduct a review within 15 days to determine the need for continued separation. The facility reported in the PAQ that in the past 12 months no resident at risk of sexual victimization was placed in isolation or held in isolation to protect them from sexual victimization. This was confirmed by the Auditor during interviews with the facility superintendent, PREA Coordinator, medical staff, and mental health staff.

Subsection (c): DJJ P&P L-101 Procedure (b)(g) ensures lesbian, gay, bisexual, transgender, queer, questioning or intersex ('LGBTQQI") residents are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status; nor shall their identification or status be used as an indicator of likelihood of being sexually abusive.

Subsection (d): DJJ P&P L-101 Procedure (b)(g) ensures that housing and programming assignments for a LGBTQQI resident is made on a case-by-case basis to ensure the juvenile's health and safety, while considering facility management and/or security concerns. Interviews with staff corroborate that the placement of LGBTQQI residents is made on a case-by-case basis.

Subsection (e): DJJ P&P L-101 Procedure (b)(g) ensures that placement and programming assignments for LGBTQQI residents is reassessed by the unit supervisor at least twice each year to review any threats to safety experienced by the resident, and documented in a JOMIS chrono, note-type "PREA."

Subsection (f): DJJ P&P L-101 Procedure (b)(g) requires staff to give serious consideration to the LGBTQQI juvenile's own opinions and views with respect to his or her own safety. A LBGTQQI resident's request for placement and program assignments shall be noted in a JOMIS chrono, note-type "PREA." Interviews with all specialized staff indicate that the views of an LGBTQQI resident are given serious consideration and they normally accommodate the resident's request for housing assignment.

Subsection (g): DJJ P&P L-101 Procedure (b)(g) ensures that LGBTQQI juveniles are provided the opportunity to shower separately from other residents, and the juvenile's preference regarding the opportunity to shower separately shall be noted in a JOMIS chrono, note-type "PREA."

Subsection (h): DJJ P&P L-101 Procedure (b)(f) ensures that whenever a resident is separated from others as a last resort, the reason is documented in JOMIS chrono, note-type "PREA." The facility reported in the PAQ in the past 12 months they have had no residents at risk of sexual victimization placed in isolation.

Subsection (i): DJJ P&P L-101 Procedure (b)(f) requires a review at least every 15 days by the unit supervisor to determine the need for continued separation need for separation from the general population. This review is documented in the JOMIS chrono, note-type "PREA."

During the on-site audit, the Auditor reviewed five random completed resident screening forms to verify that the facility uses information from the L-101.A Risk Screening form to inform housing, bed, education, and program assignments. At the time of the audit, there were no residents being housed who identified themselves as LBGTQQI at KPYF.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. KPYF Youth Handbook – *Kenai Youth Facility Guide to Success*
4. Memorandum of Understanding (MOU) with The LeeShore Center, signed August 25, 2014
5. On-site review of housing areas, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
6. Interviews with the following:
    a. PREA Coordinator
    b. PREA Compliance Manager
    c. Random Residents
    d. Random Staff

Findings (By Subsection):

Subsection (a): DJJ policy states that facilities shall provide multiple internal ways for juveniles to report sexual abuse and sexual harassment, retaliation from other juveniles or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. At a minimum, these include a locked box located on each unit and the DJJ PREA toll-free hotline posted at the facility. Residents receive information during orientation and through the PREA video on reporting PREA incidents by telling a trusted staff member, placing a note in the locked box, using a telephone to call the sexual abuse hotline; and they told they are not required to use the grievance for or formal grievance process. This was confirmed by the Auditor during on-site interviews with random staff and residents.

Subsection (b): DJJ policy states that the facility shall also provide at least one way for juveniles to report abuse or harassment to a public or private entity or office that is not part of the division, allowing the juvenile to remain anonymous upon request. Juveniles are educated on how to access the external reporting method during orientation. Policy also provides that juveniles detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. As stated in the MOU with The LeeShore Center, The LeeShore Center agrees they will receive and promptly forward resident reports of sexual abuse and harassment, and refer them to community resources, when appropriate.

During the on-site audit, the Auditor observed PREA posters with toll-free numbers in every area of the detention center and treatment center. Telephones are available in the housing areas and the residents may ask a JJO to use the telephone. Interviews with residents indicated knowledge procedures for reporting, including the use of the toll-free telephone number, and would report any incident to a staff member they trust or to their family member.

Subsection (c): DJJ policy mandates that all staff accept reports of sexual assault and sexual harassment made verbally, in writing, anonymously, and from third parties, and shall promptly document all reports on the H-100.A Facility Incident Report form. As stated in the MOU with The LeeShore Center, KPYF states they will accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. Interviews

with staff indicate they would accept verbal and written reports, they would immediately report this to the chain of command telling their JJO III, and they would document their report on the incident report form.

Subsection (d): DJJ policy ensures that the facility shall provide residents with access to tools necessary to make a written report, and will not impose a time limit on when a juvenile may submit a complaint regarding an allegation of sexual abuse. Interviews with staff indicated they would assist any resident who was unable to write their own report. As stated in the MOU with The LeeShore Center, KPYF states they will permit third parties, including fellow residents, staff members, family members, attorneys and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall permit third parties to file such requests on behalf of residents.

Subsection (e): DJJ policy states that staff are to notify their supervisors immediately and in accordance to the division facility incident notification and report policy. Staff can also privately report by utilizing the DJJ toll-free PREA hotline. Interviews with staff indicated knowledge procedures for reporting, including the use of the toll-free telephone number.

The Auditor confirmed the telephone number with the Sexual Abuse Hotline was an active telephone number and that they receive reports from KPYF residents and staff. During the pre-audit, the Sexual Abuse Hotline would not accept a telephone call from the Auditor and notified the PREA Coordinator. DJJ officials corrected the problem and the Auditor was able to leave a message on the Sexual Abuse Hotline before the filing of the Interim Report.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff, residents and advocacy services.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedure V. Sexual Abuse and Harassment Reporting, *et. seq.*,
3. DJJ P&P L-103 Resident Grievances, *et seq.*
4. Kenai Youth Facility Guide to Success
5. Interviews with the following:
    a. PREA Coordinator
    b. PREA Compliance Manager
    c. Superintendent

Findings (By Subsection):

Subsection (a): DJJ P&P L-103 IV. Response to Grievances subsection (b) states that any resident grievance that alleges assault, staff misconduct, sexual abuse, sexual harassment, or other incidents covered by the Division's Incident Notification and Reporting Policy H-100 are moved from the resident grievance process into the DJJ incident process. In such cases, the Superintendent shall take immediate steps to protect residents, and begin an internal incident review as necessary. The Superintendent will inform the resident about the incident review process and include the incident report number on the Resident Grievance Log as described later in the policy. During interviews with the PREA Coordinator, PREA Compliance Manager and Superintendent, the Auditor was told that any grievance referencing any incident of sexual harassment or sexual abuse is immediately investigated pursuant to policies and referred to the Alaska State Troopers.

Subsection (b): Pursuant policy outlined above, any resident grievances alleging assault, staff misconduct, sexual abuse, sexual harassment are removed from the resident grievance process and handled by the Superintendent and JJO III.

Subsection (c): The grievance procedures are explained to residents on page 6 of the resident handbook, Kenai Peninsula Youth Facility Guide to Success where the resident is told the first step is to make at least one good faith attempt to resolve the problem informally by discussing the issue with staff or shift supervisor. There is no mention in the handbook that grievances of sexual abuse or sexual harassment are exempt from the grievance procedure and are handled differently.

Subsection (d): Pursuant policy outlined above, any resident grievances alleging assault, staff misconduct, sexual abuse, sexual harassment are removed from the resident grievance process and handled by the Superintendent and JJO III. In the past 12 months the facility reported receiving one grievance regarding sexual harassment by other residents that was investigated. The Auditor reviewed the Investigation file during the on-site audit and confirmed that staff following agency procedures as set out in the DJJ PREA Incident Review.

Subsection (e): As stated in the MOU with The LeeShore Center, KPYF states they will permit third parties, including fellow residents, staff members, family members, attorneys and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall permit third parties to file such requests on behalf of residents.

Subsection (f): Pursuant policy outlined above, any resident grievances alleging assault, staff misconduct, sexual abuse, sexual harassment are removed from the resident grievance process and are immediately handled by the Superintendent and JJO III.

Subsection (g): The facility reports they would discipline a resident for the following of a false report of sexual abuse or sexual harassment only after a thorough investigation and according to their disciplinary procedures.

Corrective Action:

> DJJ must ensure that the Kenai Peninsula Youth Facility Guide to Success is revised to add language that complaints regarding sexual abuse and sexual assault are exempt from the grievance process. Provide Auditor with updated sections of the juvenile manual for the detention center with revisions to grievance procedures as they relate to sexual assault and sexual harassment.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 28, 2018 to evidence and demonstrate corrective action taken by DJJ and KPYF administration regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. Kenai Peninsula Youth Facility Guide to Success

KPYF enhanced Kenai Peninsula Youth Facility Program Manual regarding the handling of any grievance reports on PREA related incidents. The resident manual for KPYF has been revised to clearly define grievance procedure and the handling of PREA grievances. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
3. KPYF Youth Handbook – *Kenai Youth Facility Guide to Success*
4. Memorandum of Understanding (MOU) with The LeeShore Center, signed August 25, 2014
5. On-site review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
6. Interviews with the following:
    a. Superintendent
    b. PREA Coordinator
    c. PREA Compliance Manager
    d. Random Staff
    e. Random Residents
    f. Advocacy Services

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VI(c) states that the facility PREA Compliance Manager shall ensure victim services are made available to all juveniles under DJJ who were victims of sexual assaults while in secure care or community detention facilities or programs. The facilities shall provide juvenile victims with access to outside victim advocates by providing, posting, or otherwise making accessible mailing addresses and telephone numbers where available, of local, state or national victim advocacy or rape crisis organizations, and for persons detained solely for civil immigration purposes, immigrant services agencies. Facility staff shall enable reasonable communication between juveniles and these organizations and agencies, in as confidential manner as possible. Through a signed a MOU with The LeeShore Center, KPYF complies with this subsection and DJJ policy. Through telephone conversation with the Executive Director at The LeeShore Center, the Auditor confirmed residents at KPYF will be provided with outside victim advocates for emotional support services as outlined in this Standard.

Residents are provided information on the toll-free hotline telephone numbers for the 24-hour Sex Abuse Hotline and the Child Protection Services Hotline through PREA posters located throughout the facility. Parents are provided contact and information on the agency's website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx. During the on-site audit the Auditor observed posters displaying the contact information throughout the facility, including the housing wing, kitchen, library, classroom, medical and mental health areas, and hallways, providing residents with the address and toll-free number for outside victim services. The Auditor was able to determine through

interviews with random staff and residents that residents are aware of how to access outside confidential support services in cases of sexual abuse and where the telephone numbers are located.

Subsection (b): DJJ P&P L-100 Procedures VI(c) states that facility staff shall enable reasonable communication between juveniles and these organizations and agencies, in as confidential a manner as possible. Facility staff shall inform juveniles, prior to giving them access, of the extent to which such communications are monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility superintendent shall maintain or attempt to enter into memoranda of understanding ("MOU") or other agreement with community service providers that are able to provide juveniles with confidential emotional support services related to sexual abuse. The facility shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

Residents are advised of this limit to confidentiality by medical/mental health staff.

Subsection (c): DJJ P&P L-100 Procedures VI(c) states the facility superintendent shall maintain or attempt to enter into memoranda of understanding ("MOU") or other agreement with community service providers that are able to provide juveniles with confidential emotional support services related to sexual abuse. The facility shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

Subsection (d): DJJ P&P L-100 Procedures VI(c) states the facility shall also provide juveniles with reasonable and confidential access to their attorneys or other legal representation, if applicable, and reasonable access to parents or legal guardians. Residents are provided this information page 21 of the handbook. Residents confirmed they can meet with their parents and attorneys in a private area.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. Memorandum of Understanding (MOU) with The LeeShore Center, signed August 25, 2014
4. KPYF Youth Handbook – *Kenai Youth Facility Guide to Success*
5. DJJ website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
6. On-site Audit review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
7. Interviews with the following:
    a. Superintendent
    b. PREA Coordinator
    c. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): DJJ policy ensures that agency shall maintain a method to receive third-party reports of sexual abuse and sexual harassment via the telephone and email, and this information is distributed on the DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx. Residents are also provided information on their right to not be sexually abused or harassed and their right to report on page 6 in the resident handbook. As stated in the MOU with The LeeShore Center, KPYF states they will accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

The Auditor was able to determine through interviews with random residents and staff that both residents and staff are of the procedures for third-party reporting. The Auditor also confirmed that the telephone number and email published by DJJ on the website receives reports on sexual abuse and sexual harassment, and will distribute this information to the facility.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
4. DJJ P&P L-100 Attachment A *PREA Incident Decision Tree*, dated March 7, 2014
5. DJJ Form H-100.A Facility Incident Report
6. DJJ P&P C-3 Protective Services Reporting, *et seq.*, effective April 5, 2016
7. DJJ P&P H-100 Incident Notification and Reporting, *et seq.*, effective July 1, 2014
8. Interviews with the following:
    a. Superintendent
    b. Medical and Mental Health Staff
    c. Random Staff
    d. Random Residents

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures V(d) requires all staff to immediately notify their supervisor, immediately and according to the division facility incident notification and reporting 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 division; retaliation against juveniles or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Subsection (b): DJJ P&P C-3 Protective Services Reporting states that all DJJ employees shall be considered mandatory reporters as Defined by Alaska Statute 47.17.020, and all DJJ employees who, in the performance of their duties have reasonable cause to suspect that a child has suffered abuse or neglect shall immediately report the harm by filing a Protective Services Report ("PSR") with the Office of Children's Services ("OCS"). A PSR may be filed by calling the OCS central intake office or the local OCS office, or filed by email, fax or hand-delivery. Confirmation of receipt of the report shall be noted in the DJJ incident report. The DJJ employee making a PSR shall document this report according to the Incident Notification and Reporting Policy H-100 in Incident Tracker.

Subsection (c): DJJ P&P L-100 Procedures V(d) prohibits staff from discussion PREA allegations with anyone other than to the extent necessary, to make treatment, and other security and management decisions.

Subsection (d): DJJ P&P L-100 Procedures V(d) requires medical and mental health care practitioners to inform juveniles at the initiation of services of their duty to report and the limitations of confidentiality.

Subsection (e): DJJ P&P H-100 Procedures specifically addresses the requirements of this subsection the Standard requiring the facility superintendent and/or Shift Supervisor or designee to promptly report the allegations as required by DJJ policies and procedures and the subsections of this Standard.

Subsection (f): DJJ P&P L-100 Procedures VI(a) states that upon learning of a potential sexual abuse incident, staff will contact their supervisor and utilize the *PREA Incident Decision Tree*, Attachment A, to determine how to proceed. The PREA Incident Decision Tree diagrams when an incident will be referred to law enforcement for investigation.

Through interviews with staff, as well as interviews with medical and mental health staff, it was determined that all staff have a duty to immediately report any knowledge, suspicion, or information related to sexual abuse or sexual harassment. Staff is also required to report any retaliation towards any inmate or staff for reporting and any staff neglect that may have contributed to an incident or retaliation. Interview with the facility Superintendent indicated that he is aware of his duties to notify the parties as set forth in subsection (e) of this Standard.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. Interviews with the following:
    a. Superintendent
    b. PREA Coordinator
    c. Random Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures V(e) requires an employee that learns a juvenile is subject to a risk of imminent sexual abuse to take immediate action to protect the juvenile, including consider changes to the juvenile's housing or program assignment to separate the alleged victim and perpetrator, notification of the JJUS or center duty officer, and documentation of the allegation in the Incident Tracker information system. As of the date of the audit,

the facility reported in the PAQ that within the past 12 months they have not received or made any determination that a resident was subject to a substantial risk of imminent sexual abuse.

Interviews with staff it was determined that staff were they take immediate action to protect the safety of the resident when they receive a report that a resident is subject to risk of imminent sexual abuse.

Compliance with this standard was determined through policy reviews, and interviews with staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. Interviews with the following:

a. Agency Head
b. Superintendent
c. PREA Coordinator

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 V(f) requires that upon receipt of a report that a juvenile was sexually abused while confined at another facility, the staff receiving the allegation shall notify their supervisor, the juvenile's probation officer, and initiate an incident report. The superintendent of the facility that received the allegation shall notify the superintendent or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency within 72 hours. As of the date of the audit, the facility reported that in the past 12 months they have not received any allegation that a resident was abused while confined at another facility.

Subsection (b): DJJ P&P L-100 V(f) requires the superintendent of the facility that received the allegation shall notify the superintendent or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency within 72 hours. Interview with the facility superintendent confirmed that he would notify the superintendent or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency within 72 hours.

Subsection (c): DJJ P&P L-100 V(f) states that alleged incidents occurring at non-DJJ facilities are generally recorded under "Probation" incident types.

Subsection (d): DJJ P&P L-100 V(f) requires the superintendent of the facility that received the allegation notify the appropriate investigative agency within 72 hours of receiving the report. As of the date of the audit, the facility reported within the past 12 months they have not received any allegation that a juvenile was abused from other facilities.

During the separate interviews with the Division Director and facility Superintendent they stated that all allegations of sexual abuse and sexual harassment received from another facility will be investigated.

Compliance with this standard was determined through policy reviews, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
4. DJJ P&P L-100 Attachment A *PREA Incident Decision Tree,* dated March 7, 2014
5. DJJ P&P Form L-100.A PREA Incident Checklist
6. Interviews with the following:
    a. Superintendent
    b. Random Staff
    c. Non-security Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VI(a) states that staff will contact their supervisor and utilize the PREA Incident Decision Tree to determine how they proceed. If the incident appears to be criminal, the shift supervisor or designee will initiate the facility's PREA Incident Checklist (Form L-100.A) and contact law enforcement to conduct an investigation. The facility reported in the PAQ that within the past 12 months they have received no allegations that a resident was sexually abused.

Subsection (b): DJJ P&P L-100 Procedures V(d) requires contract employees, teachers and volunteers who know or have reasonable cause to suspect that a juvenile has been abused or neglected, must immediately report the matter to the shift supervisor, the administrator, or the designee.

Through interviews with a random staff and non-security staff it was determined that staff are knowledgeable regarding their first responder duties upon first learning of any allegation of sexual abuse or sexual harassment, and are knowledgeable on the utilization of the forms and checklists developed by the agency.

Compliance with this standard was determined through policy reviews, and interviews with staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P H-100 Incident Notification and Reporting, *et seq.*, effective July 1, 2014
3. DJJ Form H-100.A Facility Incident Report
4. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
5. DJJ P&P L-100 Attachment A *PREA Incident Decision Tree*, dated March 7, 2014
6. DJJ P&P Form L-100.A PREA Incident Checklist
7. Interviews with the following:
    a. Superintendent
    b. Random Staff
    c. Non-security Staff

Findings (By Subsection):

Subsection (a): DJJ has developed a written institutional plan and created forms and checklists to coordinate actions among staff responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse. Interview with the Superintendent confirmed the facility has a written plan and checklist for staff to follow.

Through interviews with a random staff and non-security staff it was determined that staff are knowledgeable regarding their first responder duties upon first learning of any allegation of sexual abuse or sexual harassment, and are knowledgeable on the utilization of the forms and checklists developed by the agency.

Compliance with this standard was determined through policy reviews, and interviews with staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. Collective Bargaining Agreements located at http://doa.alaska.gov/dop/LaborRelations/unionContracts
3. Interviews with the following:
    a. Agency Head

Findings (By Subsection):

Subsection (a): DJJ ensure that the agency or any other governmental entity responsible for collective bargaining on KPYF's behalf shall not enter into or renew any collective bargaining agreement or other agreement that limits KPYF's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. As part of the PAQ documentation, the Auditor was informed there are several collective bargaining agreements currently in effect which can be found at

http://doa.alaska.gov/dop/LaborRelations/unionContracts. The Auditor verified with the DJJ Director that none of the collective bargaining agreements contain language prohibits the agency or facility from disciplining or firing staff.

Subsection (b): N/A

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting*, et seq.*
3. Interviews with the following:
   a. Agency Head
   b. Superintendent
   c. Staff Member Charged with Monitoring Retaliation – PREA Compliance Manager
   d. Random Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures V(g) outlines the agency's policy or protection for juveniles 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. The PREA Compliance Manager maintains the records at the facility and files a report to the facility superintendent, chief probation officer, and the PREA Coordinator. During the interviews with the PREA Compliance Manger, Superintendent, and PREA Coordinator, the Auditor was informed that KPYF has established a policy to protect all residents and staff from retaliation as set out in this Standard.

Subsection (b): DJJ P&P L-100 Procedures V(g) provides multiple protection strategies, such as housing changes for juvenile victims or abusers, removal of alleged staff abusers from contact with victims, and emotional support services for juveniles or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The facility Unit Supervisor and PREA Compliance Manager monitors retaliation monitoring on the JOMIS chrono, note-type PREA.

Subsection (c): DJJ P&P L-100 Procedures V(g) requires the PREA Compliance Manager to monitor for at least 90 days the conduct or treatment of staff who reported sexual abuse and 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, and shall act to promptly remedy any such retaliation. The PREA Compliance Manager stated he would monitor longer than the 90-day period. As of the date of the audit, the facility reported no incidents of retaliation have occurred within the past 12 months.

Subsection (d): DJJ P&P L-100 Procedures V(g) requires the PREA Compliance Manager to monitor for at least 90 days the conduct or treatment of juveniles who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by juveniles or staff, and shall act to promptly remedy any such retaliation.

Subsection (e): DJJ P&P L-100 Procedures V(g) states that if any other individual who cooperates with the investigation expresses a fear of retaliation, the PREA Compliance Manager shall pursue appropriate measures to protect that individual against retaliation.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures V. Sexual Abuse and Harassment Reporting, *et seq.*
3. DJJ P&P L-101 PREA Risk Screening, *et seq.*
4. Interviews with the following:
    a. Superintendent
    b. Staff Member Who Supervises Residents in Isolation
    c. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures V(g) states that any use of protective separation to safeguard a juvenile who is alleged to have suffered sexual abuse shall be subject to the requirements of the PREA screening policy. The PREA screening policy is set out in DJJ P&P L-101 Procedures (f), which states that during periods of protective separation facilities shall not deny large muscle exercise, educational or other services, receive daily visits by medical or mental health staff. The Unit Supervisor will conduct a review within 15 days to determine the need for continued separation. The Auditor was informed by KPYF Superintendent, PREA Compliance Manager, and staff that they do not use isolation for any reason. As of the date of the audit, the facility reported no resident who alleged to have suffered sexual abuse were placed in isolation within the past 12 months.

Interviews with Superintendent and staff who supervise residents in isolation indicate that isolation is never used at KPYF and not for residents who have alleged sexual abuse. Interviews with medical staff indicate that any resident in isolation is seen daily by the nurse. Mental health staff will also see residents in isolation as needed.

Compliance with this standard was determined through policy reviews, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
3. DJJ P&P L-100 Attachment A, PREA Incident Decision Tree
4. DJJ P&P Form L-100.A PREA Incident Checklist
5. DJJ P&P Form L-100.C PREA Incident Review Template
6. DJJ P&P A-5, Administrative Investigations of Staff Misconduct, *et seq.*, effective January 9, 2015
7. Interviews with the following:
   a. Superintendent

b. PREA Coordinator
c. PREA Compliance Manager
d. Investigator

Findings (By Subsection):

Subsection (a): Upon learning of potential sexual abuse incident, KPYF staff follows the PREA Incident Decision Tree, Attachment A, and will initiate facility regular incident response, discipline, and supervision policies and procedures only when the incident is clearly not criminal. DJJ P&P A-5 Procedure (a) states that incidents or allegations of incidents that involve sexual abuse or sexual harassment will be reviewed by the shift supervisor or designee to ensure they have followed reporting and response requirements consistent with the division's Prison Rape Elimination Act policy. Criminal investigations are conducted by local law enforcement which is the Kenai Police Department and/or Alaska State Troopers.

Subsection (b): DJJ P&P L-100 Procedures VI states that the shift supervisor or designee, will initiate the facility's PREA Incident Checklist, Form L-100.A, and contact law enforcement to conduct an investigation. The PREA Compliance Manger shall request local law enforcement agencies conduct criminal investigations as required by national PREA Standards. DJJ P&P A-5 Procedure (a) states that law enforcement will provide guidance on the investigatory process, interviews, and evidence collection. The Auditor spoke with an Investigator at the Kenai Police Department who confirmed they have received specialized training in sexual abuse investigations involving juvenile victims as required by Standard 115.334.

Subsection (c): DJJ P&P L-100 Procedures VI states that law enforcement conducts any investigation. DJJ P&P A-5 Procedure (a) states that law enforcement will provide guidance on the investigatory process, interviews, and evidence collection. The Auditor spoke with an Investigator at the Kenai Police Department who confirmed that as part of their investigation they gather and preserve direct and circumstantial evidence, including any available physical evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Subsection (d): DJJ P&P L-100 Procedures VI states that law enforcement conducts any investigation. DJJ P&P A-5 Procedure (a) states that law enforcement will provide guidance on the investigatory process, interviews, and evidence collection.

Subsection (e): DJJ P&P L-100 Procedures VI states that law enforcement conducts any investigation. DJJ P&P A-5 Procedure (a) states that law enforcement will provide guidance on the investigatory process, interviews, and evidence collection.

Subsection (f): DJJ P&P L-100 Procedures VI states that law enforcement conducts any investigation. DJJ P&P A-5 Procedure (a) states that law enforcement will provide guidance on the investigatory process, interviews, and evidence collection.

Subsection (g): During the Sexual Abuse Incident Review and utilizing Form L-100.C PREA Incident Review Template, investigations include an effort to determine whether staff actions or failures to act contributed to the abuse and documentation is found in the Incident Tracker Information System.

Subsection (h): Local county law enforcement conducts criminal investigations according to their policies, which normally in practice adhere to the requirements for this Standard.

Subsection (i): Local law enforcement shall refer substantiated allegations of conduct based on their investigative process that appear to be criminal for prosecution. The facility reports in the PAQ that in the past 12 months there have been no criminal cases referred for prosecution.

Subsection (j): The agency tracks the requirements of this subsection of the Standard related to records retention and comply with this subsection.

Subsection (k): DJJ P&P A-5 Procedures (5)(F) states that the investigators shall complete the investigation and incident response even if the employee's status changes before it is finished (for example, if the employee resigns).

Subsection (l): N/A

Subsection (m): DJJ P&P L-100 Procedures VI(a)(4) states that staff assigned to monitor a criminal investigation will request the relevant information from local law enforcement agency.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P A-5, Administrative Investigations of Staff Misconduct, *et seq.*, effective January 9, 2015
3. Interview with the following:
   a. PREA Coordinator

Findings (By Subsection):

Subsection (a): Subsection (a): DJJ P&P A-5 states that findings and recommendations contained in the written reports shall be based upon the preponderance of the evidence standards. This was confirmed by the Auditor during the interview with the PREA Coordinator.

Compliance with this standard was determined through policy review and interview with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VI. Incident Response and Juvenile Services, *et seq.*
3. DJJ Form H-100A. Facility Incident Report
4. DJJ P&P Form L-100.A PREA Incident Checklist
5. DJJ P&P Form L-100.C PREA Incident Review Template
6. Interviews with the following:
    a. Superintendent
    b. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VI(a)(4) states that the staff assigned to monitor a criminal investigation will indicated in the incident report whether the law enforcement investigation supports a finding that a crime has occurred, the allegation is false, the evidence is inconclusive, or law enforcement declined to investigate. The staff monitoring the investigation will request the relevant information form the investigating entity as needed to inform the juvenile of the outcome. DJJ P&P L-100 Procedures VI(b) states the PREA Compliance Manager will inform the juvenile the results if the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The facility reports in the PAQ that no administrative investigations were completed by the facility in the past 12 months. The Auditor interviewed the PREA Compliance Manager who stated that the practice is to notify the juvenile as required by this subsection.

Subsection (b): DJJ P&P L-100 Procedures VI(a)(4) states that the staff assigned to monitor a criminal investigation will indicated in the incident report whether the law enforcement investigation supports a finding that a crime has occurred, the allegation is false, the evidence is inconclusive, or law enforcement declined to investigate. The staff monitoring the investigation will request the relevant information form the investigating entity as needed to inform the juvenile of the outcome. The facility reports in the PAQ that in the past 12 months there have been no criminal cases referred for prosecution.

Subsection (c): DJJ P&P L-100 Procedures VI(b) details the required notifications pursuant to this subsection of the Standard.

Subsection (d): DJJ P&P L-100 Procedures VI(b) details the required notifications pursuant to this subsection of the Standard.

Subsection (e): DJJ P&P L-100 Procedures VI(b) requires documentation by the PREA Compliance Manager in JOMIS, chrono note type PREA. The facility reports in the PAQ that there have been no administrative or criminal investigations in the past 12 months.

Subsection (f): N/A

Compliance with this standard was determined through policy reviews, review of documentation, and observations made during the on-site audit.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VIII. Disciplinary Actions, *et seq.*
3. Interviews with the following:
    a. Agency Head
    b. PREA Coordinator

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VIII(a) states disciplinary sanctions for violations of sexual abuse or sexual harassment policies shall be commensurate with the nature and circumstances of the acts committed. Sanctions will be determined in consultation with the department's human relations unit and consistent with current employee contracts, and termination shall be the presumptive disciplinary sanction for staff who engage in sexual abuse.

Subsection (b): DJJ P&P L-100 Procedures VIII(a) states termination shall be the presumptive disciplinary sanction for staff who engage in sexual abuse. The facility reports in the PAQ that no staff from the facility have been terminated or resigned prior to termination for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

Subsection (c): DJJ P&P L-100 Procedures VIII(a) states disciplinary sanctions for violations of sexual abuse or sexual harassment policies shall be 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. The facility reports in the PAQ that no staff from the facility has been disciplined, short of termination for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

Subsection (d): DJJ P&P L-100 Procedures VIII(a) states the staff responsible for the administrative investigation shall ensure all terminations for violations of division sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VIII. Disciplinary Actions, *et seq.*
3. Interviews with the following:
    a. Agency Head
    b. PREA Coordinator
    c. Superintendent

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VIII(b) states any contractor or volunteer who engages in sexual abuse or harassment shall be prohibited from contact with juveniles and shall be reported to law enforcement agencies by the facility, unless the activity was clearly not criminal, and to relevant licensing bodies. The facility reports in the PAQ that

no contractors or volunteers from the facility have been reported to local law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of juveniles in the past 12 months.

Subsection (b): DJJ P&P L-100 Procedures VIII(b) states the facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with juveniles, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer

Compliance with this standard was determined through policy reviews and interview with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VIII. Disciplinary Actions, *et seq.*
3. Interviews with the following:
    a. Superintendent
    b. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VIII(c) states that residents are subject to the disciplinary process and may be subject to disciplinary sanctions pursuant to a facility review board finding that the juvenile engaged in juvenile-on-juvenile sexual abuse or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse. As of the date of the audit, the facility reported in the PAQ that there have been no administrative or criminal findings of guilt of resident-on-resident sexual abuse in the past 12 months.

Subsection (b): DJJ P&P L-100 Procedures VIII(c) provides that residents may be subject to disciplinary sanctions only pursuant to a facility review board. Disciplinary sanctions shall be commensurate with the nature and circumstances of the incident, the juvenile's disciplinary history, and the sanctions imposed for comparable offense by other juveniles with similar histories. In the event a disciplinary sanction results in the isolation of a juvenile, agencies shall not deny the juvenile daily large-muscle exercise or access to any legally required educational programming or special education services; they shall receive daily visits from a medical or mental health care clinician; and they shall also have access to other programs and work opportunities to the extent possible. As of the date of the audit, the facility reported in the PAQ that no resident has been placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse in the past 12 months.

Subsection (c): DJJ P&P L-100 Procedures VIII(c) states the disciplinary process shall consider whether a juvenile's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanctions, if any, should be imposed. The Auditor interviewed the facility Superintendent who indicated this is the practice of the facility.

Subsection (d): DJJ P&P L-100 Procedures VIII(c) addressed the requirements of this subjection regarding offering residents therapy, counseling or other interventions as part of the discipline. The agency may require participation in such 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 to general programming or education. Interviews with medical and mental health staff indicate the practice is compliant with this subsection.

Subsection (e): DJJ P&P L-100 Procedures VIII(c) permits disciplinary sanctions on residents for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Subsection (f): DJJ P&P L-100 Procedures VIII(c) prohibits any disciplinary sanctions for 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.

Subsection (g): DJJ P&P L-100 Procedures VIII(c) prohibits all sexual activity between juveniles and may sanction a juvenile for such activity.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-101 PREA Risk Screening Procedure, *et seq.*
3. Attachment A Mental Health/Suicide Screening
4. JJO Health Intake Assessment Form
5. MAYSI-2 Questionnaire
6. DJJ Trauma Screening Tool
7. On-site review of administrative area where resident files are stored to determine security of records
8. Interviews with the following:
    a. Medical and Mental Health Staff
    b. Staff Responsible for Risk Screening

Findings (By Subsection):

Subsection (a): DJJ P&P L-101 Procedure (c) states that staff will ensure that the unit supervisor shall offer a juvenile who disclosed prior victimization or sexual abusive behavior the opportunity to meet with a mental health clinician within 7 days of the screening. As of the date of the audit, the facility reported in the PAQ that 2 residents have

disclosed prior victimization during screening within the past 12 months and were offered a follow-up meeting with medical or mental health practitioner. The Auditor reviewed five random resident's files during the on-site audit for compliance with this Standard. Interviews with medical and mental health staff indicate they offer a follow-up meeting with mental health within 14 days, if not sooner, of the initial screening.

Subsection (b): DJJ P&P L-101 Procedure (c) states that staff will ensure that the unit supervisor shall offer a juvenile who disclosed prior victimization or sexual abusive behavior the opportunity to meet with a mental health clinician within 7 days of the screening. As of the date of the audit, the facility reported in the PAQ that no residents have disclosed prior victimization during screening within the past 12 months, and were offered a follow-up meeting with a mental health practitioner. The Auditor reviewed five random resident's files during the on-site audit for compliance with this Standard.

Subsection (c): DJJ P&P L-101 Procedure (e) states that staff will only share information obtained by the screening, as necessary, to inform treatment plans and security and management decisions, including housing, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The shift supervisor on each unit is responsible for conveying necessary information to staff on potential victimization or sexually aggressive classification of a juvenile at the beginning of each shift. During the on-site audit, the Auditor confirmed with a unit supervisor that this information is conveyed to staff.

Subsection (d): DJJ P&P L-101 Procedure (d) states that if a juvenile discloses information about incidents of sexual abuse, neglect, maltreatment, or exploitation of children during the course of screening, staff will report the information as required by the division's protective service reporting (PSR) policy and incident notification and reporting policy, as set outlined in DJJ P&P H-100. Interviews with medical and mental health staff indicate they obtain informed consent from residents as outlined in this subsection.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VII. Emergency and Ongoing Medical and Mental Health Services, *et seq.*
3. Interviews with the following:
    a. Medical and Mental Health Staff
    b. Security First-Responders and non-Security Staff

Findings (By Subsection):

Subsection (a): DJJ policy demonstrates compliance with this subsection. Interviews with medical and mental health staff indicate that a victim would receive the medical services required by this subsection.

Subsection (b): DJJ policy demonstrates compliance with this subsection. Interviews with first responders indicate they will take steps to protect the victim and immediately notify the appropriate medical and mental health care practitioners.

Subsection (c): DJJ policy ensure that resident victims of sex abuse while incarcerated shall be 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.

Subsection (d): DJJ policy ensures that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperate with any investigation arising out of the incident.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures VII. Emergency and Ongoing Medical and Mental Health Services, *et seq.*
3. Interviews with the following:
    a. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures VII(e) states that the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continual care following their transfer to, or placement in, other facilities, or their release from custody.

Subsection (b): DJJ policy demonstrates compliance with this subsection.

Subsection (c): DJJ policy demonstrates compliance with this subsection.

Subsection (d): DJJ P&P L-100 Procedures VII(f) states that juvenile victims of sexually abusive vaginal penetration shall be offered pregnancy test.

Subsection (e): DJJ P&P L-100 Procedures VII(f) states that if pregnancy results from sexual abuse, such victims shall receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services, per AS 18.16.020.

Subsection (f): DJJ P&P L-100 Procedures VII(g) ensures that juvenile victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate.

Subsection (g): DJJ P&P L-100 Procedures VII(d) ensures that all treatment services to the victim shall be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Subsection (h): DJJ P&P L-100 Procedures VII(h) states when deemed appropriate by mental health professional, the facility shall offer a mental health evaluation and offer treatment of all known juvenile-on-juvenile abusers within 30 days of learning such abuse history.

There were no medical records related to the provisions as required by this Standard for the Auditor to review as the facility reported they have had no incidents of sexual abuse within the past 12 months. Medical and mental health staff interviewed stated that the care that would be offered immediately and would be consistent with the community level of care. The treatment is to be offered immediately upon being reported to medical and mental health staff at no financial cost to the resident irrespective of whether the resident/victim names the abuser or cooperates with any investigation arising from the incident.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures IX. Data Collection, Review, *et seq.*
3. Form L-100.C PREA Incident Review Template
4. Interviews with the following:
    a. Superintendent
    b. PREA Coordinator
    c. PREA Compliance Manager
    d. Member of Sexual Abuse Incident Review Team

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures IX(a) requires the PREA Compliance Manager to lead an incident review of very PREA related incident within 30 days of the conclusion of every criminal investigation or disciplinary process, substantiated or unsubstantiated, unless the allegation is determined to be unfounded. The facility reported in the PAQ that no criminal or disciplinary administrative investigations were completed in the past 12 months. Interview with the PREA Compliance Manager confirmed that he would lead a sexual abuse incident review team as set forth in DJJ policy and this Standard.

Subsection (b): DJJ policy states the review shall ordinarily occur within 30 days of the conclusion of the investigation. The facility reported in the PAQ that no criminal investigation or disciplinary process investigations of alleged sexual abuse in the past 12 months for review by the sexual abuse incident review team.

Subsection (c): DJJ P&P L-100 Procedures IX(a) states that the review team shall members of facility management, with input from line supervisors, medical or mental health practitioners as needed. The PREA Compliance Manager shall consult with the deputy director of operations before selecting the review team for incidents that qualify as a Level 1 incident under the statewide facility incident notification and reporting policy, as outlined in DJJ P&P H-100. In these cases, the review team should include individuals from another facility or office who would represent an effectively objective perspective.

Subsection (d): DJJ Form L-100.C PREA Incident Review Template details all the items that the review team must consider when conducting the review and the policy is compliant with the Standard requirement. DJJ P&P L-100

Procedures IX(a) states that the PREA Compliance Manager will provide a narrative of the incident review in the Incident Tracker Information System, and the PREA Coordinator and the facility superintendent shall be notified to review the incident review.

Subsection (e): DJJ P&P L-100 Procedures IX(a) states that the superintendent shall implement any recommendations for improvement or shall document the reasons for not doing so.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures IX. Data Collection, Review, *et seq.*
3. DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
4. Interviews with the following:
    a. Agency Head
    b. Superintendent
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures IX(b) requires the PREA Coordinator to maintain, review, and collect data from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews for every allegation of sexual abuse and harassment at DJJ facilities annually.

Subsection (b): DJJ policy ensures compliance with this Standard.

Subsection (c): DJJ P&P L-100 Procedures IX(b) states that the data collected shall include, at a minimum, the data included in the survey of sexual violence conducted by the Department of Justice.

Subsection (d): DJJ policy ensures compliance with this Standard..

Subsection (e): DJJ does not contract with private facilities for the confinement of its residents.

Subsection (f): Upon request, DJJ shall provide all such data from the previous calendar year to the Department of Justice no later than June 30th. A copy of the agency's reports are available on the agency's website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

Corrective Action: None.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures IX. Data Collection, Review, *et seq.*
3. DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
4. Interviews with the following:
    a. Agency Head
    b. Superintendent
    c. PREA Coordinator
    d. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): DJJ P&P L-100 Procedures IX(c) states that the PREA Coordinator, in coordination with the PREA Compliance Mangers, shall annual review collected incident data and prepare a written report for the division director

to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, practices, corrective action and training, at individual facilities and at the division level,

Subsection (b): DJJ policy states that such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an analysis of incident reviews.

Subsection (c): DJJ policy does not require that the annual report shall be approved by the Division Director and made readily available to the public through its website or, if it does not have one, through other means. The 2015 Annual Report available on the website was not approved or signed by the Division Director.

Subsection (d): DJJ policy does not require or mention the redaction of specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

Corrective Action:

1. DJJ needs to revise their policy to include the following:
   (1) stating that the annual report shall be approved by the Division Director and made readily available to the public; and
   (2) stating the agency will redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, and also indicate the nature of the material redacted.
2. DJJ must develop and finalize a written annual report for calendar years 2016 and 2017, and demonstrate that these reports have been approved the division director as required by this Standard, including all subsections.
3. Provide a copy of Annual Reports for calendar year 2016 and 2017 to the Auditor and made available to the public through the DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 27 and 30, 2018 to evidence and demonstrate corrective action taken by DJJ regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. DJJ Policy & Procedure Change Log for DJJ P&P L-100, dated August 24, 2018
2. DJJ P&P L-100 Procedure IX. Data Collection, Incident & Annual Review, Auditing, *et. seq.*, dated August 24, 2018.
3. 2016 Prison Rape Elimination Act Annual Report
4. 2017 Prison Rape Elimination Act Annual Report
5. DJJ Website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAAnnualReports.aspx

DJJ enhanced DJJ L-100 Procedures IX with the addition of subsection (d) outline the frequency and scope of audits as outlined in this Standard. The Agency provided the Auditor with a copy of the Prison Rape Elimination Act Annual Report for 2016 and 2017 signed by the DJJ Director as required by this Standard. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures IX. Data Collection, Review, *et seq.*
3. State of Alaska Records Retention and Disposition Schedule No. 06-180.2, *et seq.*
4. State of Alaska Data and Research Policy
5. DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx
6. Interviews with the following:
   a. Agency Head
   b. Superintendent
   c. PREA Coordinator

Findings (By Subsection):

Subsection (a): DJJ policy ensures that data collected pursuant to this Standard are securely retained.

Subsection (b): DJJ does not have a policy that states shall 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. However, DJJ has not made this data available to the public

through its DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx Annual Reports for calendar years 2016 and 2017.

Subsection (c): DJJ policy states that before making aggregated sexual abuse data publicly available, DJJ shall remove all personal identifiers and comply with this Standard.

Subsection (d): State of Alaska Records Retention and Disposition Schedule No. 06-180.2, *et seq.* outlines how long records, including records on sexual abuse data, are maintained.

Corrective Action:

1. DJJ needs to revise their policy to include the following: stating the agency shall 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.
2. Provide a copy of Annual Reports for calendar year 2016 and 2017 to the Auditor and made available to the public through the DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 27 and 30, 2018 to evidence and demonstrate corrective action taken by DJJ regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. DJJ Policy & Procedure Change Log for DJJ P&P L-100, dated August 24, 2018
2. DJJ P&P L-100 Procedure IX. Data Collection, Incident & Annual Review, Auditing, *et. seq.*, dated August 24, 2018.
3. DJJ Website http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx.

The Agency provided the Auditor with a copy of the Prison Rape Elimination Act Annual Report for 2016 and 2017 signed by the DJJ Director as required by this Standard. This Standard is now fully compliant.

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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? (N/A before August 20, 2016.)
  ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☒ Yes ☐ No

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*)

Evidence Reviewed (documents, interviews, site review):

1. KPYF Completed Pre-Audit Questionnaire ("PAQ")
2. DJJ P&P L-100 Procedures IX. Data Collection, Review, *et seq.*
3. Interviews with the following:
    a. Agency Head
    b. Superintendent
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): DJJ policy does not address this subsection. DJJ has conducted audits on all of its facilities during the three-year period starting on August 20, 2013, and has contracted for audits of all of its facilities for the second three-year period cycle.

Subsection (b): DJJ has ensured that at least one-third of each facility type operated by DJJ was audited starting August 20, 2013. DJJ does not have any facilities operated by a private organization on its behalf.

Subsection (h): DJJ policy does not address this subsection. During the audit, the Auditor had access to and observed all areas of the audited facilities.

Subsection (i): DJJ policy does not address this subsection. During the audit, the Auditor was permitted to request and received copies of any relevant documents, including electronically stored information.

Subsection (m): DJJ policy does not address this subsection. During the audit, the Auditor was permitted to conduct private interviews with residents at the facility.

Subsection (n): DJJ policy does not address this subsection. During the audit, residents were permitted to send confidential information or correspondence to the Auditor in the same manner as if they were communicating with legal counsel.

The best practice would be for the agency to modify DJJ P&P L-100, *et seq.,* to reflect the addition of subsections (h), (i), (m), and (n) of this Standard 115.401 into their policy.

Corrective Action:

DJJ must revise DJJ P&P L-100, *et seq.,* to reflect the addition of subsections (h), (i), (m), and (n) of Standard 115.401 into their policy, and submit documentation showing these revisions to the Auditor.

Verification of Corrective Action since the Audit

The Auditor was provided supplemental documentation on August 24, 2018 to evidence and demonstrate corrective action taken by DJJ regarding this Standard. This documentation is discussed below.

Additional Documentation Reviewed:

1. DJJ Policy & Procedure Change Log for DJJ P&P L-100, dated August 24, 2018
2. DJJ P&P L-100 Procedure IX. Data Collection, Incident & Annual Review, Auditing, *et. seq.*, dated August 24, 2018.

DJJ enhanced DJJ L-100 Procedures IX with the addition of subsection (d) outline the frequency and scope of audits as outlined in this Standard. This Standard is now fully compliant.

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*)

Evidence Reviewed (documents, interviews, site review):

1. 2015 Final Report on DJJ website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx

Findings (By Subsection):

Subsection (f): DJJ has published on its website at http://dhss.alaska.gov/djj/Pages/GeneralInfo/PREAOverview.aspx the Kenai Peninsula Youth Facility Final Audit Report, dated March 17, 2015.

Corrective Action: None

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.

Sharon G. Robertson

Sharon G. Robertson October 16, 2018

Auditor Signature **Date**