PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 1/13/2017

Auditor Information			
Auditor name: Susan Heck			
Address: PO Box 6032, Williamsburg, VA			
Email: susanheckva@gmail.com			
Telephone number: 757-784-1675			
Date of facility visit: November 14-17, 2016			
Facility Information			
Facility name: Lynchburg Youth Group Home			
Facility physical address: 1404 Florida Avenue, Lynchburg, VA 24501			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 434-455-4061			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☒ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Dan Fallen, Residential Services Director			
Number of staff assigned to the facility in the last 12 months: 32			
Designed facility capacity: 28			
Current population of facility: 11 (when questionnaire filled out; 10 on day of on-site audit)			
Facility security levels/inmate custody levels: Low			
Age range of the population: 12-17			
Name of PREA Compliance Manager: JT Smith, III		**Title:** Compliance Officer	
Email address: jt.smith@lynchburgva.gov		**Telephone number:** 434-455-4076	
Agency Information			
Name of agency: City of Lynchburg, Department of Juvenile Services			
Governing authority or parent agency: *(if applicable)* City of Lynchburg, Department of Juvenile Services			
Physical address: Department of Juvenile Services, 99 Ninth Street, Lynchburg, VA 24504			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 434-455-5850			
Agency Chief Executive Officer			
Name: Dan Fallen		**Title:** Residential Services Director	
Email address: dan.fallen@lynchburgva.gov		**Telephone number:** 434-455-5802	
Agency-Wide PREA Coordinator			
Name: JT Smith, III		**Title:** Compliance Manager	
Email address: jt.smith@lynchburgva.gov		**Telephone number:** 434-455-4076	

AUDIT FINDINGS

NARRATIVE

The City of Lynchburg, Department of Juvenile Services' Lynchburg Youth Group Home (LYGH) serves the cities of Lynchburg and Bedford, and the counties of Amherst, Appomattox, Bedford, Campbell, Charlotte and Nelson. The LYGH had its ribbon cutting on August 5, 2016, formally combining the City's two group homes, Opportunity House and SPARC House, into one facility located right beside the Lynchburg Regional Juvenile Detention Center. The two facilities are connected by an outside covered walkway.

The Juvenile Services Director provides leadership and supervision to the Division's residential youth programs: Lynchburg Regional Juvenile Detention Center, Lynchburg Youth Group Home and the non-residential programs: Post-Dispositional services, Outreach Detention Services (GPS), Community Casework Services, Residential Aftercare Program, Youth and Prevention Services and Comprehensive Services Act (CSA).

The on-site portion of the LYGH audit started on November 14, 2016 and concluded on November 17, 2016. This auditor met with the PREA Coordinator/PREACompliance Manager to finalize staff interview schedules and select residents to interview. The facility tour was conducted on 11/14/16 and included the PREA Coordinator of the facility. All areas of the facility were toured; a detailed description of the tour is below under "Description of Facility Characteristics". The facility has a capacity of 28.

On the day of the audit, 10 youth were in population at LYGH. All ten of the residents were interviewed to meet the auditing standard of interviewing a minimum of ten. No residents in current population had reported abuse while at the facility; no LBGTI residents were currently in population.

The facility reports having 32 staff; ten random staff interviews were conducted, including staff from all three shifts and covering all units (this number includes both full and part-time/relief workers). Since this is a small facility without designated staff for intake, five of these staff (different shifts) were also interviewed as staff who conduct resident education at intake and staff who administer vulnerability assessments. In addition to interviews conducted with direct care workers, 11 specialty interviews were conducted with other staff members based on job functions and duties at the facility. In total, 31 distinct interviews were conducted with staff at LYGH with several staff members taking part in multiple interviews.

Facility policy states that all allegations of sexual abuse and sexual harassment are investigatied; the facility had one investigator to handle administrative and sexual harassment investigations at the time of the onsite audit; he has taken the Investigator Training provided by the PRC through NIC. This auditor recommended that another administrative staff member be trained as an investigator to ensure proper handling of administrative investigations of sexual abuse or sexual harassment and that staff member was identified and trained during the 60 days after the on-site audit and before issuance of the final report. Criminal investigations are referred to the Lynchburg Police Department. Although there is not an MOU in place with the Lynchburg Police Department, there is a memo from the Deputy Police Chief stating that they will do all the investigations and that the Lynchburg Police Department(LPD) is the designated investigative agency. LPD has the legal authority to conduct such investigations. There is a memorandum on file detailing the Lynchburg Department of Social Services' role in any investigation; since Lynchburg Social Services (including Child Protective Services) is in the same department (Lynchburg Juvenile Services) as LYGH, any allegation received by City of Lynchburg Child Protective Services regarding a resident of LYGH will be referred to the Department of Child Protective Services in a neighboring jurisdiction to avoid any conflict of interest. Victim advocates for emotional support services related to sexual abuse may be accessed 24/7 by calling the YWCA of Central Virginia, Sexual Assault Response Program (SARP).

DESCRIPTION OF FACILITY CHARACTERISTICS

Lynchburg Youth Group Home (LYGH) is a brand new, one-story, mostly brick and concrete building which houses both male and female detainees from the ages of 11-17. Residents are placed by local Social Services and through court order and are low to medium custody levels. This is a non-secure group home and has the ability to screen residents for placement appropriateness prior to admission.

The facility was completed in August of 2016, and has a very open design with excellent visability throughout. The front of the building has a stone wall beside the entrance. The entrance is monitored with a camera and visitors ring a bell to gain entry. The Notice of Audit was clearly visible and posted on the entrance. Once in the lobby, the Intake area for residents is through a door on the right, the door on the left leads to administrative offices (not accessible to residents), and the door at the end of the hall leads to another hallway which leads to another small foyer with entrances to the visitation room, resident living and sleeping areas areas, and an additional outside entrance.

The Intake area, located through a door on the right of the lobby, houses two small offices (one is a staff office and the other is the intake interview room) a waiting area, and a shower and laundry area. The waiting room is just outside the intake interview room. This area also includes a laundry area for intake use and a shower for intakes; staff stand outside the shower door. The shower has breakaway shower rods and handicap rails. This area is covered by the facility's camera system. Residents are "searched" using a metal detecting wand; this facility does not do pat-down searches of its residents at any time. There are three PREA posters in this area, including posters in Spanish. Residents complete intake in this area including watching a DVD on PREA. They are given a PREA brochure at intake. (Resident Handbooks available on the unis.) Notice of PREA Audit was also posted here.

At the back of the lobby is the door leading to a small second foyer with entrances to the visitation room, the housing units for residents, and a door to the outside of the building that has a covered walkway to the Lynchburg Regional Juvenile Detention Home (LRJDC) located right beside LYGH.

The visitation room is glass-walled on one side and had several PREA posters; the Notice of Audit was on the door. This area also held a private interview room for meeting with attorneys/social workers, etc. The room has very good camera coverage. The windowed wall looks out to a courtyard that can also be used for visitation in nice weather.

A door at the back of the second lobby leads into the main housing area for residents. The hallway leading to the housing units has an entrance to gym and also the dining room (meals are provided by the LRJDC next door) which can also be used as extra space for visitation. (The dining room and gym are side by side and are at the center of this part of the building. Hallways on each side of them lead to other staff offices, classrooms, etc.) The dining room has one wall of windows that look over the courtyard between the the visitation room and the dinig room; there were four PREA posters, two in Spanish. There is excellent camera coverage. Along this same hallway are the casework office (half glass door into a room comprised of cubicles with half walls), and a small interview room which houses the telephone for residents to use to contact Child Protective Services; there are posters here, none in Spanish, also with a half glass door. This auditor called the "hotline" and spoke with hotline staff who answered. (Additional training recommended, however, this is a brand new process for both CPS and LYGH.) In addition, there are two staff training rooms located along the hall, each of which has one windowed wall; no residents are allowed in these rooms. They are secured and have cameras. A camera monitors all activity on this hallway. The door at the end of the hall leads to the housing units, gym and medical exam rooms.

Once through the door at the end of the hall, the medical unit is on the right. It is comprised of a waiting area, an exam room (no camera coverage here), a staff office, medication room, laundry and a waiting room. All doors which were supposed to be locked were secure. This auditor suggested posters in the waiting room area.

The entrances to all four housing units are in a semi-circle facing the gym with the medical office to the right and bathrooms on either side of the semi-circle. The door to the gym faces the living units and is secured. There are posters in this area and signs on each of the living unit doors reminding staff to announce when the opposite gender is entering the area.

Each housing unit is designed basically the same way. The door opens into a large room, very light with windows at one end, a large seating area with comfortable couches in the middle, and a door that leads to a small outside patio. Sleeping/bedrooms line one wall. There are two female housing units and two male housing units. There is a door connecting the two female units and a door connecting the two male units. The laundry area is just inside the main door to each of the housing units and in full view of the rest of the large activity/living room. There were three PREA posters, one in Spanish in all of the housing units and the Notice of PREA Audit was posted in each one. There is a small alcove to the right after entering each of the living areas which is used as a "Time-Out Alcove"; it has a rocking chair and a half wall to facilitate supervision by staff. There is also a dedicated camera covering this area. There are also two cameras on opposite corners which provide excellent overall coverage of the room. There are two bathrooms; residents shower one at a time and do all bathing, toileting and changing of clothers in the bathroom. No cameras are in the bathrooms and all bathrooms were built with the breakaway shower curtain rods. In the male units there are five sleeping rooms; three double rooms and two single rooms. The double rooms are equipped with a laser monitor to alert staff if a resident crosses to the other side of the room during the night. On the female units there are four bedrooms; two doubles and two singles. The staff desk is along one side of the room across from the bedroom/sleeping rooms with clear access all around it; the Resident Handbook was out and available. The adjoining door between the two

male and two female units helps with night coverage. There are a total of 18 sleeping rooms; 8 single occupancy and 10 double occupancy.

A hallway on the opposite side of the gym from the casework office and staff training rooms has classrooms which are not currently in use. Residents at this facility leave the facility to go to school. These rooms are currently being used for storage and are secured. There are also bathrooms along this hall that are secured when the area is not in use. There is an additional door to both the dining room and the gym on this hallway. The back part of the building after leaving the second smaller foyer has two hallways with offices or classrooms with the gym and dining room in the middle; the end of the building is the housing units.

The facility is brand new and has been built with maximum visability and several of the newest innovations (like the laser light that alerts staff to resident movement inside the room when activated). It is evident that the City of Lynchburg took great care in the design and building of this facility and is a tangible example of their commitment to the youth in their service area.

SUMMARY OF AUDIT FINDINGS

The on-site audit of Lynchburg Youth Group Home (LYGH) was completed on November 17, 2016.

Compliance with the PREA standards and a true commitment to keep residents in their care safe and free from sexual abuse and sexual harassment is evident at LYGH. All staff interviewed expressed faith in their administrative team and a genuine concern for the residents.

Sincere thanks to JT Smith (PREA Coordinator/PREA Compliance Manager) for his help throughout the on-site audit process and throughout the interim period following the on-site leading to the issuance of this Final Report. His responsiveness to questions and quick turnaround on recommended changes contributed greatly to the ability to provide this report in a timely manner. His dedication to this facility was evident from the beginning and is to be highly commended. His commitment to the youth served at this facility is clear and he took on the task of leading the facility's PREA compliance with dedication. He sees this initial audit as a first step and was planning future efforts as this audit was concluding.

Number of standards exceeded: 1

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3; 115.312-this facility does not contract with other facilities for the confinement of its youth, 115.352 Exhaustion of Administrative Remedies, 115.366-Virginia is a non-union state

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
Lynchburg Regional Juvenile Detention Center and Lynchburg Youth Group Home Prison Rape Elimination Act Policy*, A. Zero Tolerance
SOP 58, Prevention and Intervention of Sexually Abusive Behavior
Reviewed job description of Compliance Manager/Lynchburg Youth Group Home
Interview with PREA Coordinator/Compliance Manager

*Note: The Lynchburg Regional Juvenile Detention Center and the Lynchburg Youth Group Home Prison Rape Elimination Act Policy is hereafter referred to as the "PREA Policy" in this document.

PREA Policy clearly articulates Zero Tolerance policy. In addition, SOP 58 "Prevention and Intervention for Sexually Abuse Behavior" addresses Zero Tolerance goals and expectations and disciplinary strategies for staff (including contractors and volunteers) and residents.

PREA Coordinator position is not on an organizational chart; a newly created job description, "City of Lynchburg Juvenile Services Certification and Training Manager", articulates PREA compliance responsibilities. A memorandum from the Director of Residental Services designates JT Smith, Lynchburg Youth Group Home Compliance Officer, as the current PREA Coordinator/Compliance Manager for the agency and he has the time and is positioned in the agency in a way that is conducive to performing these responsibilities. The agency has two residential facilities; Lynchburg Regional Juvenile Detention Center (LRJDC) and Lynchburg Youth Group Home (LYGH). Lynchburg Youth Group Home Compliance Officer/PREA Coordinator reports to Director of Lynchburg Juvenile Services.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Contracting with other entities for the confinement of residents.

This standard does not apply to this facility. It does not contract with any other agency for the confinement of its residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Supervision and monitoring
Lynchburg Regional Juvenile Detention Center Operational and Policy Manual, Supervision and Control
SOP 61, Unannounced Rounds
Interview with Superintendent
Interview with administrative staff who conduct unannounced rounds
Review of Unannounced Rounds log
Meeting notes for annual review of staffing plan
Form documenting staffing plan review with signatures

Staffing at this facility is currently 1:10 but is on target for meeting the 2017 1:8 PREA requirement. Lynchburg Regional Juvenile Detention Center and Lynchburg Youth Group Home Staffing Plan details staffing plan currently in effect at LRJDC and LYGH under Commonwealth of Virginia's Department of Juvenile Justice standards and also under PREA standards. The superintendent stated that the facility routinely reviews its staffing needs and calls in additional help when necessary. This happens during administrative team staff meetings but has not been formally documented as required by the PREA standard. In addition, City of Lynchburg, VA, Lynchburg Regional Juvenile Detention Center Operational and Policy Manual, Supervision and Control, pg. 39 describes supervision procedures in detail. Superintendent stated facility has good coverage and a good cadre of relief staff to help the facility maintain its staffing ratio. There have been no incidents of failing to adhere to the staffing plan. Interview with PREA Coordinator and Superintendent indicate that close attention is given to each element of the standard, especially since this facility houses both male and female residents.

The formal annual staffing plan review as required by PREA standards is a new practice for this facility. The PREA Policy now includes all elements of the standard to be considered in the annual review of the staffing plan. The facility has developed a Staffing Plan review document that includes signatures lines for the Director of Residental Services and the PREA Coordinator. During the on-site audit de-brief meeting the decision was made to designate a specific Administrative Team monthly meeting for this review each year to ensure it receives the required focus. The review in November was the first review and will be modified in the future to include the new form and will document the staffing plan discussion in more detail.

This auditor reviewed Unannounced Rounds Log and encouraged making them more "PREA specific" to differentiate them from regular management rounds. This facility's Administrative Management Team adheres to "Management by Walking Around" and makes rounds daily at various times during the day. Staff and residents are accustomed to seeing the Administrative Staff throughout the building. Unannounced Rounds Log covers all areas of the facility and covers all shifts, day and night.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, D. Limits to cross-gender Viewing and Searches
Resident Handbook
Interviews with secure staff
Interviews with residents
Interview with medical staff

PREA Policy mirrors the standard. Resident and staff interviews confirm the facility's no cross-gender pat search policy. Residents are searched, but no cross-gender searches are conducted. All resident and staff interviews confirmed the facility's policy that residents may bathe, toilet, and change clothing without being viewed by staff of opposite gender.

There are no transgender or intersex residents currently in population, so no interviews with this specific population were conducted.

LYGH does NOT do pat-downs searches of any type on residents. The use of a metal detecting wand is employed, but staff do not touch residents at any time. If there is any cause for convern, LPD come to the facility and conduct the search. Although some staff members stated that they had received training on cross-gender pat-downs, these were part-time staff who also work at the Lynchburg Regional Juvenile Detention Center next door. (The two facilities share relief staff.) This facility is exempt from this part of this standard per PRC Auditor Support Helpline.

There have been no cross-gender strip or visual body cavity searches done at this facility, including no searches of this nature by medical practitioners. Anything requiring this type of search would require transport to outside medical practitioners. There have been no incidences of cross-gender strip searches, cross-gender visual body cavity searches or cross-gender pat-down searches.

Resident and staff interviews confirm that staff announce their presence when they enter the housing unit of opposite gender.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, E. Residents with disabilities and limited English
Interview with agency head
Interviews with residents
Interviews with secure staff
Review of resident brochure (also in Spanish)
Review of resident handbook (also in Spanish)
Facility tour; noted posters (also in Spanish)

Facility has done a good job of having important information translated into Spanish and identifying resources within the City's structure to provide for translation services for any youth requiring them. The resident handbook, brochures and posters have been translated into

Spanish, the most often represented language other than English, and are hung in facility. Staff and residents were aware that residents could not and should not translate for other residents and none could remember this occurring.

Interview with Residential Services Director confirmed that services are available through the City of Lynchburg for residents who are not English speaking.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, F. Hiring and promotion
Review of HR policy for City of Lynchburg
Interview with HR hiring manager at facility
Review of facility personnel files (reviewed files of all staff interviewed during on-site audit)

The facility's policy is consistent with all elements of the standard. All required background checks are conducted. The City of Lynchburg has hiring practices and procedures in place for all city departments/agencies which require background checks compliant with PREA standards.

Facility utilizes a form entitled PREA Questionnaire for Fitness to Hire, Promote or Continue Contract to ensure appropriate questions are asked. Form includes boxes to check for promotion, interview or during evaluation process. All elements of this standard are included on the form. Form also reminds staff of continuing duty to report/disclose any such conduct. Facility's PREA Policy employs a continuing duty to report on all staff, volunteers, contractor

All files reviewed (this auditor reviewed files of all staff who took part in an interview) had required background checks along with a five year re-background as applicable.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A Upgrades to facilities and technology
Interview with PREA coordinator
Interview with superintendent
Review of control room monitors showing feed from all cameras

The facility is brand new and has an extensive camera system with excellent camera placement covering housing and general purpose areas within the facility. The camera feed was reviewed to ensure it did not show residents while bathing, toileting or dressing. System is not actively monitored, but camera footage can be specifically or randomly pulled for review or for investigative purposes.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, F. Hiring and promotion, pg. 5,
Memo from Deputy Chief, Lynchburg Police Department
Cooperative Agreement between YWCA of Central Virginia and LYGH
Interviews with staff
Interview with PREA Coordinator/Comliance Manager

Facility PREA Policy mirrors standard. Facility does administrative investigations only and refers any allegation that is potentially criminal in nature to Lynchburg Police Department (LPD). The LPD investigates allegations of sexual abuse; they know the requirement for using developmentally appropriate protocol for youth.

A Cooperative Agreement between YWCA of Central Virginia and LYGH is in place to provide victim advocacy and support services through its Sexual Abuse Response Program (SARP), including support during forensic exam and through any criminal investigative process. Residents may also contact the YWCA's rape crisis line or national hotline; information and numbers are provided to residents through brochures and posters in the facility.

Resident victims of sexual abuse would be transported to Lynchburg General Hospital for SAFE/SANE forensic examination at no cost to resident; SAFE/SANE staff available 24/7. No forensic exams are conducted at the facility.

Staff know that all allegations of sexual abuse and sexual harassment are investigated. They articulated requirement to report everything to administration for referral.

No residents who reported sexual abuse while at the facility were available in current population.

The facility will only conduct administrative sexual abuse investigations.

There has been one allegation of sexual abuse in the past 12 months; investigation was reviewed and efforts detailed were compliant with PREA standards.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Policies to ensure referrals of allegations for investigations
PREA Policy, INVESTIGATIONS, A. Criminal and administrative agency investigations,
Memo from Chief Deputy, LPD
Interview with Investigative staff
Interview with Director of Residential Services (Agency Head representative)

Facility policy mirrors standard. There has been one (resident to resident) allegation of sexual abuse or sexual harassment. This allegation was referred for possible criminal investigation and declined for prosecution. Administrative investigation reviewed and compliant with PREA Standards.

LYGH has clear policies that all allegations of sexual abuse or sexual harassment will be investigated. Facility staff tasked with administrative investigations have done the required training through NIC/PRC. Memo from Chief Deputy indicates that LPD will do investigations. LPD aware of PREA Standards as they relate to conducting investigation, collecting evidence, etc. LPD has the legal authority to conduct such investigations.

The description of responsibilities for investigating allegations of sexual abuse is on the facility's website.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Training for Staff, contractors, interns and volunteers
Review of training records of all staff interviewed
Review of PowerPoint curriculum
Interviews with secure staff

Facility PREA Policy mirrors standard and includes all elements in standard. Staff stated that they had been trained on all elements in the standard. Facility houses both male and female residents and training covered both. Training records of all staff interviewed were reviewed; two relief staff were missing training records; this has now been covered and is in compliance.

Employees/contractors sign statement indicating that they received and understood training received. PowerPoint training reviewed and covers all required elements. Policy states that training is tailored to population of residents.
Subsequent annual training has reinforced and added to PREA information for staff.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Training for Staff, contractors, interns and volunteers
Review of training records volunteer and contractor interviewed
Review of PowerPoint curriculum
Interview with volunteer
Interview with contractor

Reviewed PowerPoint presentation which includes all required elements. Volunteer and contractor training would mirror staff initial training. This facility does not currently have volunteers. LYGH PREA Policy covers training for volunteers and contractors if any are used in the future.

Standard 115.333 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Resident Education
Reviewed brochure, "Resident Handbook on Sexual Misconduct (also available in Spanish)
Reviewed Resident PREA Education Form
Interviewed Intake Staff
Interviewed residents (all ten current residents interviewed)

Residents are trained on the date of intake on zero tolerance policy and all elements required by the standard. Residents also receive brochure which explains relevant PREA information. Residents sign their intake sheets which includes documentation that they received PREA training. Residents also view DVD about PREA. Files of all residents' interviewed were reviewed and indicated that they received information in the correct timeframe.

There is no designated intake unit in this facility due to its small size. Staff members are trained to do intake and conduct vulnerability assessments on all new residents. Staff members who often conduct intake education were interviewed and are knowledgeable about resident education and what should be done.

Posters and brochures were evident throughout the facility. Facility has done a nice job with making information available including posters, brochures, DVDs. Posters were up and hit key points. Information was varied to hold residents' attention. Information is available in Spanish; translation services are available as needed.

Residents weren't as clear about services available in the community; this auditor suggested additional training for residents in this area. Intake staff noted that residents are educated each time they come to the facility, whether they came from another facility or had been released for a couple of days and then came back.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Specialized training
Reviewed certificate of completion from "PREA: Investigating Sexual Abuse in a Confinement Setting" available on PRC
Interview with investigator

All investigations indicating criminal activity referred to Lynchburg PD.

Facility identified Compliance Manager (PREA Coordinator) to handle administrative investigations. He received specialized training provided through NIC/PRC, "PREA: Investigating Sexual Abuse in a Confinement Setting". Certificate on file. Investigator indicated he took the training and demonstrated knowledge of elements.

Auditor recommended that additional facility staff be designated as administrative investigators in case the one person trained to do administrative investigations is not at the facility at the time an incident is reported. Facility designated an additional staff member for this role and she participated in the required training during the 60 days following the on-site audit and before the issuance of the final report. Certificate was sent to this auditor for review.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence:
PREA Policy, D. Specialized training
Certificate of training from "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting"

Policy mirrors standard; states that medical and mental health care staff shall also receive the PREA training mandated for all employees under 115.335. This facility does not have medical or mental health staff as part of their personnel. In emergencies, the nurse from the Lynchburg Regional Juvenile Detention Center (located next to LYGH) would provide medical care in an emergency until rescue personnel arrived. The nurse at LRJDC has received required training to comply with this standard, "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting". Training certificate was provided; she has also had the PREA training provided to all employees. No forensic exams are done at the facility.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Obtaining information from residents
Interviews with residents
Interviews with staff who administer PREA Intake Screening Form, Vulnerability Assessment Instrument
Review of resident files to document assessment using objective screening tool

The facility uses an objective screening tool which includes all elements from the standard. It is given to all youth at intake; information gleened helps make housing unit decisions. Resident interviews confirmed facility's practice of assessing this information at intake.

All elements of the standard are included in the facility's PREA Intake Screening Form, Vulnerability Assessment Instrument. In addition, they use other information as available from court, parents/guardians, other placement facilities. Interviewed staff who provide residents information at intake and conduct assessments using the tool. All indicated that residents are screened at intake. Good description about who should get the information, why, and how they are to treat the information.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Evidence:
PREA Policy, B. Placement of residents in housing, bed, program, education, and work assignments
Interviews with staff who conduct risk screening
Interview with PREA coordinator
Interview with residents

Facility policy mirrors standard. No residents have been placed in isolation due to risk of sexual victimization. Facility indicates that it does not use isolation. There has been one allegation in the past 12 months. Administrative investigation report reviewed by this auditor and was compliant with PREA standards. No transgender or intersex residents in population at this time. Population management and security given consideration during placement decisions. All residents at this facility shower separately.

PREA Coordinator/Compliance Manager indicated ways information used to make housing and program assignments.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Resident Reporting,
Resident handbook
Resident brochure, "Resident Handbook on Sexual Misconduct"
Resident interviews
Staff interviews
Interview with PREA coordinator

Staff interviewed said they accepted verbal reports, and documented them immediately. Staff knew they could report outside the facility but all indicated that they had complete confidence in their administrators to report any and all abuse or neglect of residents.

Reviewed brochure, posters with reporting information. Facility has done a good job with resident brochure explaining how to report; brochure was updated with list of resources available to victims of sexual abuse. Posters (where available) reinforce PREA education for residents and were available in Spanish as well as English.

Residents have multiple ways to report including a way to report outside the facility. Residents were knowledgeable about ways to report. Residents are allowed to put a written allegation of sexual abuse or sexual harassment in the "grievance" box; note that any communication from a resident alleging sexual abuse or sexual harassment goes to PREA Coordinator for immediate investigation and moves outside the facility's grievance process. Grievance policy/procedure is consistent in describing this process.

All staff interviewed were aware that they were to accept verbal reports and indicated that they document verbal reports immediately. Residents are not detained at this facility solely for civil immigration purposes.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Exhaustion of administrative remedies
"How to Report Sexual Abuse" brochure
Resident Handbook
Interviews with resident
Interview with PREA Coordinator
Interviews with staff

NOTE: This standard is NA for this facility. LYGH has a grievance procedure that residents use to report any concerns about conditions of confinement--anything other than sexual abuse or sexual harassment. Since residents are aware of the grievance process, they are allowed to place a written allegation in the "grievance box", however, any written allegiation of sexual abuse or sexual harassment moves outside the grievance system immediately and goes to the PREA Coordinator for investigation and referral to LPD as appropriate. The facility's grievance procedure clearly differentiates the process for any allegation of sexual abuse or sexual harassment. The facility allows the use of the written notification because it is something residents are familiar with and understand.

There is a system in place for residents to submit an emergency request to see an administrator or the PREA Coordinator.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Resident access to outside support services and legal representation
Reviewed Cooperative Agreement with YWCA of Central Virginia
Reviewed "Resident Handbook on Sexual Misconduct"
Interviews with residents
Interview with PREA Coordinator/PREA Compliance Manger

Facility policy mirrors standard. Cooperative Agreement with YWCA of Central Virginia provides residents with victim witness services through its Sexual Assault Response Program (SARP). Residents all noted that they had access to their parents and to their legal representatives. Resident brochure updated to provide more contact numbers and descriptions of outside support services. Residents generally knew that services existed, but weren't able to explain what help they might provide. Suggested additional training with residents and update to resident brochure re reporting sexual abuse.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, D. Third Party Reporting
Review of facility website, www.Lynchburgva.gov, JuvenileServices Department link, PREA COMPLAINT

Facility policy mirrors standard. A form is available on the website to send to the facility by mail, email, or someone can call the LYGH. A third-party form is available on the website under "PREA Complaint". May contact PREA Coordinator by mailing to LYGH or by calling or emailing.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A Mandatory reporting and protective duties, staff and agency reporting duties
Interviews with staff
Interview with PREA Coordinator/PREA Compliance Manager
Interview with superintendent

Facility policy mirrors standard. Staff knew they could report outside the facility. All interviews indicated an understanding of the mandatory reporting responsibilities, including reporting to the juvenile court or child welfare system.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Agency protection duties
Interviews with staff
Interview with Director of Residential Services (currently oversees LYGH)

Facility policy mirrors standard. All staff interviewed indicated knowledge of the facility's duty to protect and to act on any risk of sexual abuse immediately. Director of Residential Services indicated that his expectation was that staff respond immediately. Facility has had one incident of this nature in the past 12 months.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Reporting to other confinement facilities
Interviews with staff
Interview with Director of Residential Services

Facility policy mirrors standard. All staff interviewed indicated knowledge of the facility's duty to report to other confinement facilities and to act on any report they receive about anything that happened in their own facility. Director of Residential Services understood his responsibility to report to other facilities and to respond to any reports he receives from other facilities.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, D. First Responder duties
Reviewed "PREA Incident: A Coordinated Response"
Staff interviews

Facility policy mirrors the standard and includes all required elements. "PREA Incident: A Coordinated Response" is posted in staff offices throughout the facility. Auditor suggested written protocol be added to current posted flowchart. All staff interviewed indicated knowledge of what to do if they were the first staff to receive an allegation of sexual abuse from a resident.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, E. Coordinated Response
Reviewed PREA "PREA Incident: A Coordinated Response"
Facility tour identified posted "PREA Incident: A Coordinated Response"

"PREA Incident: A Coordinated Response" flowchart is posted in all housing unit offices. Protocol is specific to LYGH. Auditor suggested a word-based protocol be added to eliminate confusion should there be an incident.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:

Interview with superintendent

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

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, F. Agency protection against retaliation
Interview with Director of Residential Services
Interview with PREA Coordinator tasked with monitoring retaliation against staff or residents.

Facility policy mirrors standard. Staff members who monitor retaliation were aware of their responsibilities and of the multiple things to monitor. They all indicated that monitoring for retaliation would continue for as long as there was any indication of need.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, G. Post-allegation protective custody
Interview with medical staff
Interviews with staff

Facility policy mirrors standard. There has been one allegation of sexual abuse (unfounded after administrative investigation) over the past twelve months and no residents who reported being at risk of sexual victimization over the past 12 months. Staff interviews indicated that the facility does not use isolation. There have been no incidences of residents being isolated as a result of a sexual abuse allegation.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Criminal and administrative agency investigations, Internal/administrative investigations
Review of training certificates of facility investigator
Review of Memorandum from Lynchburg Department of Human Services/CPS
Interview with investigator
Interview with PREA Coordinator

Facility policy closely mirrors standard. In addition, the policy does an excellent job of separating out the responsibilities and differences in a criminal and an administrative investigation. Facility will refer any allegation that appears to be criminal in nature to LPD. LPD is aware of PREA standards and their duties as they relate to same. This is a local pd.

Policy articulates the facility's responsibility to assist LPD and to attempt to remain informed about the progress of the investigation.

This auditor advised having additional facility administrators trained to conduct administrative investigations; this happened during period after on-site audit and the issuance of the interim report.

There has been one investigation of sexual abuse over the past twelve months. Investigation was reviewed; was prompt, thorough, closely followed standard including looking at staff actions which may have contributed to incident. Unfounded.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Evidentiary standard for administrative investigations
Interview with investigator

Facility policy mirrors standard. Facility investigator indicated that the facility would require no standard higher than preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

This facility has had one allegation of sexual abuse; investigation was reviewed and was consistent with standard. Unfounded.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Reporting to Residents
Interview with facility investigator
Interview with Director of Residential Services

Facility policy mirrors standard. Facility does administrative investigations only. Facility has had one allegation of sexual abuse. Investigation was reviewed and was compliant with PREA standards. Allegation was unfounded. Facility investigator and Director of Residential Services understood the facility's responsibility to notify a resident whether the allegation has been determined to be substantiated, unsubstantiated or unfounded.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Disciplinary sanctions for staff

Facility policy closely mirrors standard. There have been no terminations of staff for sexual abuse or sexual harassment.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence:
PREA Policy, B. Corrective action for contractors and volunteers

Facility policy closely mirrors standard. There are currently no volunteers at this facility so no allegations against volunteers/contractors.

Standard 115.378 Disciplinary sanctions for residents

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

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

Evidence:
PREA Policy, C. Interventions and disciplinary sanctions for residents,
Interview with Director of Residential Services

Facility policy mirrors standard. There has been one resident-resident allegation (unfounded). All sexual contact between residents is prohibited by the facility. Residents may not be disciplined for sexual contact with staff unless staff did not consent to such contact.

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

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

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

Evidence:
PREA Policy, A. Medical and mental health screenings; history of abuse

Facility policy closely mirrors standard. This facility has an excellent relationship with Horizon Behaviorial Health (formerly Community Services Board) and outside providers to provide any mental health servies to residents. Policy states that any resident disclosing prior sexual abuse or prior perpetration of sexual abuse at intake will generate a referral for a follow-up meeting with medical or mental health provider. No current residents had disclosed prior sexual abuse or prior perpetration of sexual abuse.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Access to emergency medical and mental health services
Interview with secure staff

Facility policy mirrors standard. Services are provided at Lynchburg General Hospital. No records maintained on site. Resident victims of sexual abuse would be transported to Lynchburg General Hospital.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Ongoing medical and mental health care for sexual abuse victims and abusers

Facility policy mirrors standard. This facility has had one allegation of sexual abuse at the facility (unfounded). Victim offered victim witness services. Strong community partnerships are in place to provide services as needed included Horizon Behaviorial Health of Central Virginia (formally Community Services Board) which is the community standard of care.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, A. Sexual abuse incident review
Interview with PREA Coordinator
Interview with sexual abuse incident review team members (2)

Facility policy mirrors standard. Auditor discussed facility's process for reviewing other serious incidents and found process to be thorough. Auditor talked with PREA Coordinator and members of sexual abuse incident review team about maintaining the integrity of this process for all sexual abuse allegations.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Data collection

Facility policy mirrors standard. DOJ has not requested data.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, B. Data review for corrective action
Interview with Director of Residential Services
Review of annual report
Website review

The facility provided its annual report for review; it is posted on the facility's website (see address below). Facility policy mirrors standard. www.Lynchburgva.gov, Juvenile Services Department link, LYGH tab.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, C. Data storage, publication and destruction
Interview with PREA Coordinator

Facility policy mirrors standard. There have been no reports published. Interview with PREA Coordinator indicated knowledge of the standard and the requirement to make information publicly available and to remove personal identifiers.

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Signature

January 13, 2017

Date