PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: December 4, 2015

Auditor Information			
Auditor name: Richard McVicar			
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Telephone number: 618-579-6406			
Date of facility visit: 09/14/2015			
Facility Information			
Facility name: Fletcher House			
Facility physical address: 517 Penn Street, Camden NJ 08102			
Facility mailing address: *(if different from above)*			
Facility telephone number: 856.854.4660			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☒ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Lola Oyesanmi			
Number of staff assigned to the facility in the last 12 months: 19			
Designed facility capacity: 84			
Current population of facility: 82			
Facility security levels/inmate custody levels: Full Minimum			
Age range of the population: 25-45			
Name of PREA Compliance Manager: Lola Oyesanmi		**Title:** Program Director	
Email address: loyesanmi@voadv.org		**Telephone number:** 856.854.4660	
Agency Information			
Name of agency: Volunteers of America Delaware Valley Inc.			
Governing authority or parent agency: *(if applicable)* New Jersey Department Of Corrections			
Physical address: 235 Whitehorse Pike, Collingswood New Jersey, 08107			
Mailing address: *(if different from above)*			
Telephone number: 856.854.4660			
Agency Chief Executive Officer			
Name: Daniel Lombardo		**Title:** Chief Executive Officer	
Email address: dlombardo@voadv.org		**Telephone number:** 856.854.4660	
Agency-Wide PREA Coordinator			
Name: Kathy A. White		**Title:** Vice President of Program Operations	
Email address: kwhite@voadv.org		**Telephone number:** 856.854.4660	

AUDIT FINDINGS

NARRATIVE:

On the morning of September 14th, this auditor (Rich McVicar) met with the Corporate PREA Coordinator and the Program Director for Fletcher House (FH) in Camden, NJ, for purposes of initiating a two day PREA audit. The day began with a comprehensive tour of the building. This auditor was accompanied by the above mentioned executive staff members as we toured all living areas, common areas, day room areas, the kitchen, showers, bathrooms, and the Control Room of this 84 bed facility. The facility has no medical/mental health component and relies on a nearby NJDOC (New Jersey Department of Corrections) facility for routine medical and dental needs. Local hospitals are available that provide more acute care, inclusive of SAFE/SANE (Sexual Abuse Forensic Examiner/Sexual Abuse Nurse Examiner) protocols. The total resident population at the time of the tour was 82. Seventeen of the facilities 25 staff members are dedicated to direct resident supervision. Shifts are ten hour days during the week and twelve hour shifts during the weekend. There are three direct contact staff assigned to supervise living areas on a 24 hour basis. The facility does have an extensive camera system to complement the security component. Camera feeds are monitored in the control/reception area. The camera system has recording capability for playback purposes. At the time of audit the system was not fully operational, but a technician was on site correcting the problem. With few exceptions, all common areas of the facility were monitored. Exceptions were stairwells between the first and second floor that were not under camera surveillance. It is recommended that the facility consider these areas for camera placement when possible. Security staff presence and control of the facility was appropriate for a facility of this size and security level. This auditor had the opportunity to speak informally with multiple residents, both individually and in small groups. I asked questions regarding their knowledge of the PREA and, most importantly, whether they felt safe. Residents could converse a satisfactory understanding of the PREA, and without exception felt safe at this facility. I asked to see some of their handbooks and any other PREA information they might have in their possession and each resident asked complied. The mood of the resident population was appropriate. There are five pay phones in the resident day room area. Signage provided PREA information and contact numbers for the Corporate PREA Coordinator, a regional rape crisis center (SERV), and the New Jersey DOC Ombudsman. I called the SERV hot line and was connected to a crisis counselor who advised me that their services (including advocacy) would be extended to residents of Fletcher House. I attempted to contact the Ombudsman and received a busy signal. This problem was corrected prior to the end of the audit. After the tour I was assisted with randomly selecting both direct supervision staff and residents. Telephone interviews of targeted staff were conducted prior to the on-site visit. Due to the small staffing component, I was only able to interview five staff. I interviewed ten residents, randomly selected from the resident roster. There were no residents assigned to the facility who warranted a targeted interview (LBGTI). During the second day I met again with the Corporate PREA Coordinator and the Chief Operating Officer to discuss the progress of the audit. I then finalized interviews and reviewed staff personnel files, resident master files, and clinical files. It should be noted that Fletcher House is accredited by the American Correctional Association.

DESCRIPTION OF FACILITY CHARACTERISTICS

Fletcher House is owned and operated by Volunteers of America, Delaware Valley, Inc. (VOA). It is a private not for profit operation contracting exclusively with the NJDOC. The facility provides re-entry services inclusive of a work release program. The facility provides residents programming in such areas as employment readiness, job search and cognitive behavioral interventions. Clients (residents) are received from the NJDOC within two years of their parole date. The building was renovated in the late 1980s from what was originally two older (possibly turn of the century) homes. The structure now houses the entire operation under one roof. This is a two story structure with fourteen multiple bedrooms providing for a rated capacity of 84. The facility does have a small kitchen. The basement serves as a recreational / weight lifting area. The main floor houses administrative office areas, the Control Room, living areas with facilities, a day room, and the laundry room. The second floor is exclusively used for housing. These types of structures typically have blind spots and Fletcher House is no exception. It does appear that the facility makes a solid effort to remedy that problem via staffing and monitoring technology. This facility is located near Rutgers University and blends quite well with the surrounding architecture. At the time of the tour the facility seemed to be in relatively good repair for a facility of this age and construction, and housekeeping was good. The mood of the resident population seemed appropriate and staff morale appeared to be good.

SUMMARY OF AUDIT FINDINGS

There are 39 PREA standards established for Community Based Confinement Facilities. Fletcher House (Volunteers of America, Delaware Valley, Inc.) was audited on September 14-15th, 2015. Of the thirty-nine standards, two were initially found to be not applicable, and fifteen were not met. An Interim Report was prepared, and a Corrective Action Plan was initiated. The plan was completed December 4 of this year. The facility now has three standards not applicable, and meets the requirements of thirty six standards. This document is the Final Report.

Number of standards exceeded: 0

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 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.

Policy 700.40 and corresponding local policy address this standard. The facility PREA Plan covers zero tolerance and the other sub-standards as required by this standard. In addition to the facility PREA Compliance Manager, there is a Corporate PREA Coordinator (Vice President of Program Operations), who also oversees compliance to zero-tolerance and the standard requirements. Interviews with staff and residents confirmed the zero-tolerance standard is in place and covered in training. The local PREA Compliance Manager stated she has sufficient time to complete her duties.

Standard 115.212 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.

PREA Standard 115.212 is not applicable to this facility. This facility is a private not for profit facility, and has no contracts relevant to this standard.

Standard 115.213 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.

Policy 700.40 addresses this standard. Policy requires each facility within the agency to review their respective staffing plans on an annual basis. The staffing plan is reviewed annually, taking into consideration the 84 bed capacity. Compliance to the PREA and other

safety and security issues are always of primary focus when considering and reviewing staffing plans according to the facility Program Director. The FH has been provided all necessary resources to support the programs and procedures to ensure compliance with the PREA. There has been no deviation from the staffing plan. The audit included an examination of all resident access to phones, housing assignments, and a review of all staffing rosters. "Rounds" (visits to areas in the facility) are conducted by administrative staff on a routine basis, and supervisors are able to enter the units with no warning to line staff. Also, interviews with residents and other staff confirmed that visits are conducted on an irregular basis, by administrative staff, to all areas of the facility. Program Assistants (similar to correctional officers) make "rounds" in a manner to provide excellent supervision. The video monitoring program (cameras) is sufficient to provide additional surveillance to ensure resident safety. Documentation supporting compliance to this standard was reviewed by the auditor. Staff interviews also support compliance to this standard.

Standard 115.215 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.

Policy 700.40 and 200.08 address this standard. FH is an all-male institution. The facility does not allow cross-gender pat or strip searches. All staff reported that they received cross-gender pat search training (including how to search transgender and intersex residents). Staff reported that residents are always allowed to shower, dress and use the toilet privately, without being viewed by staff of the opposite gender. Female staff stated they announce their presence verbally when entering all areas holding residents. Announcements were observed by the auditor during the tour of the facility. Staff were aware that policy prohibits the searching of a transgender or intersex resident to determine their genital status. The interviewed residents confirmed they were afforded significant privacy from all staff when using the toilet, changing clothes, or when showering, and that announcements were made when opposite gender staff entered the housing units or any area holding residents. PREA notifications (English and Spanish) are posted in each housing area and in all resident program areas. The facility is compliant with this standard.

Standard 115.216 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.

Policy 300.04 addresses the requirements of this standard. The FH takes appropriate steps to ensure residents with disabilities and residents with limited English proficiency have an opportunity to participate in and benefit from the facilities efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA handouts, postings, and resident handbooks are in English and Spanish (the facility is prepared to address the needs of other limited English speaking residents also through an interpreter service). Staff interviewed were aware that under no circumstance are resident interpreters or assistants to be used in dealing with any PREA related matter. The FH is

compliant with this standard.

Standard 115.217 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.

Policy 700.40 and 700.07 require compliance to this standard. The Corporate PREA Coordinator and Chief Operating Officer were interviewed and stated that all components of this standard have been met. Employees are asked if they have any history of sexual misconduct, and cannot be hired or promoted if they have a history of involvement with any type of sexual abuse. All employees and the volunteer have had criminal background checks completed in accordance with this standard. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy clearly states the submission of false information by any applicant is grounds for termination. The FH makes a significant effort to contact all prior institution employers for information on substantiated allegations of sexual abuse prior to hiring staff permanently. A review of documentation and staff interviews support compliance to this standard. The FH is compliant with this standard.

Standard 115.218 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.

The facility has not made significant changes to the physical plant since August 20, 2012. The facility has enhanced its video surveillance to complement the security staffing component during the period in reference. This auditor reviewed documentation that supports appropriate planning and considerations in a manner consistent with this standard. The facility meets this standard.

Standard 115.221 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.

Policies 700.33 and 700.07 require compliance with all aspects of this standard. However, for the purposes of compliance to this standard, only the Corporate PREA Coordinator conducts administrative investigations. Usable physical evidence would be collected by FH staff. The NJDOC SID (Special Investigation Division) staff conduct criminal investigations for the facility. Specific actions and clinical decisions are required to determine if an inmate is to be transported to a local hospital or the Garden State Correctional Facility to receive a SANE exam (this action is controlled by medical staff at the Garden State Correctional Facility {GSCF}). The FH has no involvement in this decision. No SANE exams were conducted within the last year. The resident will not be charged for any services related to PREA compliance. A Memorandum of Understanding was requested with the local rape crisis center, but denied. The center did agree to provide confidential services in accordance with the PREA if needed. The auditor discussed these services with the Victim Advocate from the center, who was very knowledgeable concerning available services. A review of documentation also confirmed compliance to this standard; however, most of the requirements of this standard are controlled by the GSCF.

Standard 115.222 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.

Policy 700.33 provides procedural safeguards as specified by this standard. The PREA Coordinator is responsible for conducting initial administrative investigations on all allegations of sexual abuse. If warranted (criminal), the PREA Coordinator will refer the case to the NJ Department of Corrections Office of Community Programs and the NJ Department of Corrections Special Investigation Division (SID). There have been two administrative investigations conducted this past reporting period. The allegations were determined to be unfounded and were not referred for a criminal investigation. The facility meets this standard.

Standard 115.231 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.

Policy 700.12 addresses all training required by this standard. The FH provides extensive PREA standards training during new employee orientation, of which all staff must attend and successfully complete (curriculum reviewed). Changes to policy or updates are communicated to staff as needed. Annual refresher training is also provided to all employees. The FH documents that staff understand the PREA. A review of the FH lesson plan ("Power Point") demonstrates all the required areas are covered. All staff interviewed indicated that they received the required PREA training.

Standard 115.232 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.

Policy 700.12 addresses this standard. The one volunteer received training related to their responsibilities concerning the PREA (zero-tolerance, detection, prevention, response, and reporting requirements). All training is documented and was reviewed by the auditor. All contractors will be under direct staff supervision and have no contact with residents. The Corporate PREA Coordinator and one volunteer were interviewed concerning this standard (confirmed compliance).

Standard 115.233 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.

The facility has policy (300.02) in place that requires residents to receive orientation training within eight hours of intake in sexual harassment and reporting policy. The power point presentation includes both the zero tolerance policy and a reporting mechanism. With regard to part(c) of this standard, the facility does have policy in 300.04 Rights of Detainees, but it is specific to ensuring that residents receive a listing of their rights identified in Policy 600.10. While the policy could be more specific, this auditor believes the intent and purpose is consistent with this standard. The facility does maintain a roster of residents participating in the training. The resident handbook is provided to all incoming residents (English or Spanish). The handbook has a section titled "Prison Rape Elimination Act - PREA" that does address the zero tolerance policy and a reporting method. The facility meets this standard.

Standard 115.234 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.

The Corporate PREA Coordinator conducts administrative investigations at the facility as they relate to sexual abuse or harassment allegations. This process is guided by Policy 700.33. This individual has completed a training session that satisfies the requirements of this standard. The interview process served to demonstrate this person as being knowledgeable in all aspects of the investigation process. There have been two allegations of sexual abuse that have been investigated administratively. Records of the administrative investigations have been maintained and were reviewed by this auditor. The facility meets this standard.

Standard 115.235 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.

The facility does not have a medical or mental health component. Routine medical or mental health care is provided by a nearby NJDOC facility GSCF (Garden State Correctional Facility). Emergency and forensic services are provided by community based medical facilities in coordination with medical personnel from the GSCF. NJDOC Policy MED.MLI.007 does require adherence to PREA requirements, inclusive of the additional training stipulated by this standard. This standard is not applicable.

Standard 115.241 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.

Policy 400.07 addresses the requirements of this standard. All residents are immediately assessed at intake by staff for their risk of being sexually abused by other residents or being sexually abusive towards others (none were identified within the last year). Staff screen all new arrivals within 72 hours following arrival. At the time of intake, staff also conduct additional screening by reviewing records or other information from another facility or other source which may be relevant to compliance with this standard. Residents cannot be disciplined for refusing to answer questions at intake (PREA related). Residents identified as high risk for sexual victimization or at risk of sexually abusing other residents would be referred to mental health staff for further assessment. Careful housing assignment (placement in a housing area with additional supervision) or other appropriate action would then be considered to address the resident's needs. Any information received after intake relevant to the PREA is immediately considered, and may result in a change in housing or other necessary action. Status reassessments, if necessary, will occur as indicated. Staff and resident interviews confirmed compliance to this standard.

Standard 115.242 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.

Policy 700.04 addresses the mandates of this standard. Policy requires the use of a screening form to determine housing, bed, work, education and program assignments, with the goal of keeping residents at high risk of being sexually victimized separate from those who are at a high risk of being sexually abusive. The auditor inspected several screening forms, which were found to be compliant to this standard. FH uses a system called "Secure Manage" to process data. Housing and program assignments are made on a case by case basis. There is in place a procedure for providing continued re-assessment and follow-up monitoring if needed. All documentation is considered confidential, and only disclosed to staff with a right or need to know. Staff and resident interviews, and a review of documentation, confirmed compliance to this standard.

Standard 115.251 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.

Policy 700.40 addresses this standard. A review of documentation indicated that there are multiple ways for residents to report sexual abuse or harassment. The facility does not house residents for civil immigration purposes. Staff and residents interviewed stated they may privately report any abuse, harassment, or neglect (which would contribute to a violation of the PREA) verbally, in writing, anonymously, or to a third party. Staff will immediately take all required further action when notified and document the information. Posters in the housing areas and the inmate handbook explain the reporting procedures. The FH is compliant with this standard.

Standard 115.252 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.

Policy 300.04, Rights of the Client, pg. 3, addressing this standard, is communicated to residents, and advises that if they believe their rights have been denied to follow the grievance procedures in the resident handbook. The grievance process is based on an initial review by the Program Director, and then a series of appeals should the resident not be satisfied with the outcome. Policy 600.09, Client Grievance Procedure, pg. 3, mirrors the handbook language with the exception of residents who are in substantial risk of imminent sexual abuse. In this case the policy satisfies elements of the emergency grievance provision in part (f) of this standard. The information would be communicated to the Corporate PREA Coordinator, who works off site. It is noted that there is a mailing address provided for the corporate Chief Operating Officer in the resident handbook to appeal grievances. There is also a phone number posted in the housing areas to contact the Corporate PREA Coordinator for purposes of reporting abuse. A review of documentation and staff interviews confirm compliance to this standard.

Standard 115.253 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.

Policy 400.13, Mental Health and Support Services, pg. 2 provides residents with sexual abuse histories, victims and abusers, to access confidential emotional support services. The policy also requires the case manager to facilitate connection to these services. The contact is allowed as confidentially as possible. The intent of the standard is for the client to reach out independently and directly to those organizations. The facility does provide signage with contact information for SERV (local rape crisis center), which does provide support services consistent with this standard. This auditor called the number and was connected with a counselor confirming that SERV would provide services to Fletcher House residents. The facility has not entered in to a Memorandum of Understanding with SERV, and has not been able to get an agreement in writing. Posters in the housing areas make reference to emotional support services and how to contact such services. The FH is compliant with this standard.

Standard 115.254 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.

The corporate web site contains a provision for third party reporting in a manner consistent with this standard. This auditor did access the site and noted the information. The facility meets this standard.

Standard 115.261 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.

The facility has policy and procedure in place (Policy 300.06, 700.33, 600.40 and 700.40) that satisfies all elements of this standard. Staff were well aware of their duty to immediately report all allegations of sexual abuse, sexual harassment, neglect (which would cause a PREA violation) and retaliation relevant to PREA standards. All information is maintained confidentially. A review of policy and staff interviews supports the finding that the facility is in compliance with this standard.

Standard 115.262 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.

Policy 600.10 addresses the mandates of this standard. Staff interviewed were well aware of their duties and responsibilities, as it relates to them having knowledge of an inmate being in imminent risk of being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the inmate. They also stated they would separate the potential victim/potential predator, secure the scene to protect possible evidence, not allow inmates to destroy possible evidence and contact the supervisor (who would contact medical staff at the GSCF). In the past 12 months, there were no instances in which the facility staff determined that an inmate was subject to substantial risk of imminent sexual abuse. A review of policy/documentation and staff/inmate interviews supports the finding that the facility is in compliance with this standard.

Standard 115.263 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.

Policy 700.40, Sexual Abuse and Harassment, pg. 5 provides language that provides procedural support towards compliance with this standard. Targeted staff interviews further support compliance. There have been no occurrences of such reports this past reporting period and consequently no secondary documentation. The facility meets this standard.

Standard 115.264 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.

Policy 300.06 and corresponding local procedures outline the mandates of this standard. All staff interviewed were knowledgeable concerning their first responder duties and responsibilities, upon learning that a resident may be the victim of sexual abuse. The staff interviewed quoted specific actions (such as protection of the victim, preservation of all evidence and notification to the supervisor) to be taken, in compliance with the PREA. The supervisor would then contact medical staff at the GSCF for assistance. There have been no incidents within the previous year requiring first responder actions. Staff knowledge as a first responder is considered good. The facility is compliant with this standard.

Standard 115.265 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.

Policy 700.40 addresses the mandates of this standard. Documentation was reviewed by the auditor. The documentation describes the coordinated actions to be taken by first responders, medical/mental health staff, investigators and facility administrative staff, in response to an incident of sexual abuse/harassment. There were no instances within the last year requiring a response from the FH relevant to this standard. The facility is compliant with this standard.

Standard 115.266 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.

The facility has not entered in to any collective bargaining agreements this past reporting period, nor does it have any current agreements with labor (no union). The facility can protect residents from contact with abusers. Targeted staff interviews support compliance. The facility meets this standard.

Standard 115.267 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.

Policy 700.40 corresponding local procedures outline the mandates of this standard. The policy prohibits any type of retaliation against any staff or inmate who has reported sexual abuse, sexual harassment or cooperated in any related investigation. The Program Manager (PREA Manager) is charged with monitoring retaliation. When interviewed, she stated she would follow up every 30 days to ensure policy is being enforced and conduct periodic status checks on the frequency of unjust incident reports, housing reassignments and negative performance reviews/staff job reassignments if needed. If there was a concern that there was the potential for possible retaliation, the Program Manager indicated she would monitor the situation indefinitely. There have been no incidents of suspected or actual retaliation in the past 12 months. The facility is compliant with this standard.

Standard 115.271 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.

Policy 700.33 requires that the facility report all allegations of sexual abuse and harassment including third party and anonymous reports to the NJDOC. However, Policy 700.40 states that in instances of sexual abuse or harassment of a client, the investigation is to be handled initially by the PREA Coordinator, and states that the PREA Coordinator will determine (after an initial review and or investigation) whether

the NJDOC SID (Special Investigations Division) will be notified of a potential criminal PREA incident. Targeted staff interviews support the fact that the facility does conduct administrative investigations. The PREA Coordinator has been trained sufficiently to conduct administrative investigations and has conducted two this past reporting period. There were no documented referrals to the NJDOC SID. The NJDOC SID will conduct any criminal investigations once cases have been referred by the Corporate PREA Coordinator. NJDOC SID policy and procedure supports compliance with this PREA standard as it relates to criminal investigations and the collection of evidence. The facility does have a system in place to conduct administrative investigations in a manner consistent with this standard, and to refer allegations that may be criminal to the NJDOC SID. The facility meets this standard.

Standard 115.272 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.

Facility policy 700.33, Investigations, provides language that supports compliance with this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.273 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.

Not Applicable-All residents (victim or abuser) involved in an alleged violation of the PREA are transferred to the GSFC (released from the custody of the FH). Any notification relevant to this standard would be provided by staff at that facility.

Standard 115.276 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.

Policy 700.40 requires that staff, contractors and volunteers be terminated for sexually abusing or sexual harassing clients or participating in sexual misconduct and inappropriate behavior with residents. While the standard provides more flexibility as provided in part (c) to weigh the circumstances and disciplinary history of staff members, the facility has chosen to make termination the only option. It is this auditors opinion that this is within the prerogative of the facility and that this approach satisfies the standard. All other provisions of the standard are supported by policy, procedure, and staff interviews. There have been no instances of staff, contractors, or volunteers violating the zero tolerance policy this past reporting period. The facility meets this standard.

Standard 115.277 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.

Policy 700.40, pg. 6 fully addresses the prohibition of contractors and volunteers from engaging in sexual abuse of residents. Further contact with residents is enforced. Appropriate criminal referrals and professional notifications will be made when warranted. There was no violation of this standard during the rating period. The facility meets this standard.

Standard 115.278 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.

Policy 700.40 addresses the mandates of this standard. There were two unfounded inmate to inmate sexual abuse/sexual harassment allegations investigated during the last year (the residents were transferred to the GSCF for reasons unrelated to the PREA). There have been no cases of staff and inmates engaging in sex during the past 12 months, and no cases of other staff abuse. There were no criminal findings of guilt for inmate-on-inmate sexual abuse. Therapy services would be available for victims and abusers at the facility if needed. Policy does not allow consensual sex of any nature. Inmates having sexual contact with staff will be disciplined, only if it is not consensual. The FH does not discipline inmates who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with the Corporate PREA Coordinator and Chief Operating Officer support a finding that the facility is in compliance with this standard.

Standard 115.282 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.

Policy 400.07 requires that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services coordinated through the Garden State Correctional Facility (GSCF) Medical Department, in accordance with the PREA. GSCF is a NJDOC facility guided by their policy MED.MLI.007 which supports the SANE protocol relative to a medical response and MED. MHS.001.002 relative to emergency mental health services. The facility provides victim services without financial cost as specified in part (d) of the standard. The facility meets this standard.

Standard 115.283 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.

Policy 400.07 refers victims in need of ongoing mental health services to the NJDOC Garden State Correctional Facility. NJDOC Policy MED.MLI.007 provides language consistent with this standard and subscribes to SANE protocols with regard to sexual abuse or assault. Facility policy and procedure 400.13 does require that mental health evaluations be conducted on resident abusers within 60 days of receiving that information. Policy 400.07 further provides that mental health services be provided to victims free of charge as required by the standard. There have been no cases relevant to this standard during the rating period. The facility meets this standard.

Standard 115.286 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.

Policy 700.40 outlines the mandates of this standard. The facility would conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be unfounded. The Corporate PREA Coordinator (facility investigator) was interviewed and found to be very knowledgeable concerning her duties and responsibilities in providing information to the incident review team. Based on interviews with a member of the incident review team (Chief Operating Officer), the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, other status or gang affiliation. The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. The review team consists of upper-level management. A sexual abuse incident review reporting form is completed as required. The facility is compliant with this standard.

Standard 115.287 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.

PD 700.33 Data Collection, pg. 1-4, provides language more specific to research and studies conducted at VOA facilities. However, the procedure does provide for an annual evaluation of the program with regard to whether written goals are being met. The policy goes on to state "In instances of sexual abuse or harassment, data will be collected and analyzed as part of a risk management strategy. Information collected shall include the data necessary to answer the Survey of Sexual Violence conducted by the Department of Justice". This language satisfies part (b) of the standard. The facility has posted an annual report on its web site that serves to support that incident based sexual abuse data is collected annually and aggregated. The facility meets this standard.

Standard 115.288 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.

Volunteers of America has generated an annual report containing aggregated data from July 1 of 2014 through the end of the year. There is no prior annualized report with which to make comparisons for purposes of this standard. The report is approved by the Chief Operating Officer and is posted on the corporate web site in a manner consistent with the expectations of this standard. The facility meets this standard.

Standard 115.289 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.

The facility maintains data and documentation for at least 10 years in a manner consistent with both the standard and applicable statute. An annual report is provided to the public with all personal identifiers removed. The facility meets this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

William Willingham for Richard McVicar — December 4, 2015

Auditor Signature — Date