PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: August 26, 2016

Auditor Information			
Auditor name: William Willingham			
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Email: william.willingham@nakamotogroup.com			
Telephone number: 850-718-7173			
Date of facility visit: 08/15/2016			
Facility Information			
Facility name: Hope Hall (Volunteers of America)			
Facility physical address: 676 Fairview St, Camden, NJ 081040			
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: Al Bosher			
Number of staff assigned to the facility in the last 12 months: 46			
Designed facility capacity: 175			
Current population of facility: 166			
Facility security levels/inmate custody levels: Community			
Age range of the population: 21-55			
Name of PREA Compliance Manager: Demetre Pough		**Title:** PREA Compliance Manager	
Email address: DPough@voadv.org		**Telephone number:** 856-854-4660	
Agency Information			
Name of agency: Volunteers of America Delaware Valley			
Governing authority or parent agency: *(if applicable)*			
Physical address: 235 White Horse Pike, Collingswood, NJ 08017			
Mailing address: *(if different from above)*			
Telephone number: 856-854-4660			
Agency Chief Executive Officer			
Name: Dan Lombardo		**Title:** President/CEO	
Email address: DZippy@voadv.org		**Telephone number:** 856-854-4660	
Agency-Wide PREA Coordinator			
Name: Kathy White		**Title:** Vice President of Program Operations	
Email address: KWhite@voadv.org		**Telephone number:** 856-854-4660	

AUDIT FINDINGS

NARRATIVE

The on-site visit to conduct a Prison Rape Elimination Act (PREA) compliance audit of Hope Hall (HH), Volunteers of America Delaware Valley (VOADV), was conducted on August 15, 2016. The 39 standards used for this audit became effective August 20, 2012. As part of the audit, a review of all PREA policy and related documentation was completed. The auditor also toured the entire facility. Prior to the on-site visit, the auditor held a conference call with the Agency PREA Coordinator to discuss the Pre-Audit Questionnaire and supporting documentation. At the time of this audit the facility employed 46 staff. The resident population was 166 males. Hope Hall does not house females or youthful offenders. Seven residents were interviewed, including one who was limited English proficient. There were no disabled, Bi-Sexual, Transgender or Intersex residents housed at the facility during the audit. Many residents were away from the facility on work-release during the audit. No incidents of sexual abuse or sexual harassment were reported from any resident. A total of ten staff were interviewed. Four Program Assistants (security staff) from different shifts and six specialty staff were interviewed. The specialty staff interviewed included the Director, PREA Compliance Coordinator, PREA Compliance Manager, Human Resource Manager and two Case Managers. No contractors were available to be interviewed (none had unsupervised contact with residents). Interview documentation was obtained for the President/CEO (agency head designee interviewed). A SANE (Sexual Assault Nurse Examiner) nurse from a local hospital (where exams would take place if necessary), a community Victim Advocate (Rape Crisis Center) and one volunteer were also interviewed by phone. When the auditor first arrived at the facility, a meeting was held with the Director, Agency PREA Compliance Coordinator, PREA Compliance Manager and several other administrative staff to explain the audit process. No letters were mailed to the auditor concerning the upcoming audit. One investigation was completed within the last year involving an allegation of sexual abuse, which was determined to be unsubstantiated (reviewed by auditor). During the course of the audit, any potential problems or recommendations were immediately brought to the attention of the Director.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of Volunteers of America Delaware Valley is to provide community-based assistance to populations in need so that they can lead self-fulfilled, independent lives. The goal of HH is to provide residents a transition from prison to full integration back into the community. Program objectives also intend to provide participants with the knowledge and skills necessary to develop and lead a productive lifestyle prior to returning home, and to resolve any additional issues. The facility is accredited by the American Correctional Association (ACA). HH consists of a 175 bed facility (a single building housing all residents and staff support services) for adult males, referred from the New Jersey Department of Corrections. Living areas consist of multiple occupancy dormitory-like rooms with double bunks and shared showers and bathrooms. The facility also has meeting rooms and leisure activity areas. HH is located in an urban residential neighborhood in Camden, NJ. The facility was built in 1999 by the VOADV to serve its current mission. Services and programs include religious activities, counseling, parenting skills development, adult basic education, substance abuse treatment and life-skills training (job interviews training, financial management instruction etc.). Additional services include individual assessment programs, employment assistance and housing placement referrals. Residents receive these services at the facility or in the community. Residents participate in this overall program for usually 6 to 9 months. The facility utilizes eighteen cameras to monitor activities (with recording capabilities), has adequate staff supervision and no "blind spots" (areas lacking adequate camera coverage or staff supervision) were discovered during the tour. Meals are provided at the facility, prepared by a contractor and served by residents.

SUMMARY OF AUDIT FINDINGS

When the on-site audit was completed, a meeting was held with the administrative staff, to discuss the overall audit process and results. The auditor had been provided extensive and lengthy files of documentation prior to and during the audit, in an effort to support a conclusion of compliance with the PREA. During the course of the on-site visit, staff were found to be courteous, cooperative, and professional. The interviewed residents stated they felt safe at the facility. Staff and resident morale appeared to be excellent. All areas of the facility toured were found to be clean and well maintained, considering the age of the facility. At the conclusion of the audit the auditor thanked the HH staff for their hard work and commitment to the PREA. A summary of the audit findings are listed below:

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.

The facility policy 700.40 addresses the requirements of this standard. The policy outlines how the facility deals with preventing, detecting, and responding to sexual abuse and harassment. The Agency has a designated agency wide PREA Coordinator who oversees the agency's compliance with the PREA. Zero tolerance is discussed in the resident handbook that is provided to all newly arriving residents upon intake. Zero tolerance postings are located throughout the facility. The review of training records and staff interviews confirmed that staff and volunteers who have regular or frequent contact with residents receive PREA related training during initial orientation and again annually. The PREA Coordinator and facility PREA Manager stated they have sufficient time to administer their responsibilities to oversee PREA compliance. Compliance with this standard was determined through interviews with staff, residents, observations and an examination of policy/documentation.

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.

Not applicable. The facility and VOADV do not contract for the confinement of residents with other entities.

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.

Facility policy 200.02 addresses this standard. Policy requires the facility to review the respective staffing plan annually, taking into consideration the 175 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 Director. HH 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 daily basis, and supervisors are able to enter the housing areas with no warning to line staff. Also, interviews with residents and line staff confirmed that visits are conducted on an irregular basis, by administrative staff, to all areas of the facility. Program Assistants 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 and resident interviews, as well as observations, also support compliance.

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.

Facility policy 200.08 addresses this standard. The facility does not allow cross-gender visual or strip searches (involving the inspection of body cavities). Cross gender pat searches are allowed only to identify contraband. All staff reported that they received cross-gender pat search training (including how to search Transgender and Intersex residents in a professional manner). 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), stating opposite gender staff work in the area, are posted in each housing area and in all resident program areas. Staff and resident interviews, as well as observations, support compliance to 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.

Facility policy 300.04 addresses the requirements of this standard. HH 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. Staff and resident interviews, as well as observations, support compliance to 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.

Facility policy 700.06 requires compliance to this standard. The Human Resources Manager was interviewed and stated that all components of this standard have been met. Employees cannot be hired if they have a history of involvement with sexual abuse. All employees, volunteers and the contractor have had criminal background checks completed. Staff also conduct background checks before approving staff promotions. 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. HH makes a significant effort to contact all prior institution employers for information on substantiated allegations of sexual abuse prior to hiring staff permanently. HH 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.

Facility policy 100.05 addresses this standard. The video monitoring system consists of eighteen cameras with recording capabilities, monitored by staff, placed in hallways and activity areas. There have been upgrades to this system since August 20, 2012.

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.

Facility policy 700.33 requires compliance to all aspects of this standard. Specific actions and clinical decisions are required to determine if a resident is to be transported to the local hospital to receive a SANE exam. No SANE exams were conducted within the last year. Staff interviewed were knowledgeable of procedures to separate the victim and perpetrator; isolating any witnesses; chain of command notifications; appropriate referrals and securing and obtaining usable physical evidence when sexual abuse is alleged. All allegations of sexual abuse or sexual harassment are forwarded to the NJDOC for investigation and disposition. If the allegation is criminal in nature, the local police department would also be notified. If needed, residents will be transported to a local hospital for forensic medical examination by qualified medical staff. The local Rape Crisis Center has agreed to provide victim advocate services when requested by the resident. All services will be provided at no cost to the resident. Compliance with this standard was confirmed through staff interviews and policy review. The resident will not be charged for any services related to PREA compliance. A Memorandum of Understanding was initiated with the local Rape Crisis Center to provide confidential services if needed. The auditor discussed these services with the local PREA Victim Advocate, who was very knowledgeable concerning available services. A SANE nurse from the local hospital was also interviewed. The PREA Victim Advocate also indicated HH was PREA compliant concerning this standard. A review of documentation also confirmed compliance to this standard.

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.

Facility policy 700.33 requires compliance to all aspects of this standard. Administrative or criminal investigations are completed on all allegations of sexual abuse and sexual harassment. An investigator was interviewed and found to be extremely knowledgeable concerning their responsibilities under the PREA. The NJDOC investigators initiate all investigations. The HH staff will work closely with the facility investigators on administrative/criminal investigations. There was one investigation inspected by the auditor, and was found to be proper and complete (unsubstantiated). A review of documentation and staff interviews confirmed compliance to 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.

Facility policy 700.12 requires compliance to all aspects of this standard. The VOADV 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 (also required by the ACA accreditation). Staff acknowledge in writing their understanding of the PREA. The acknowledgement form lists all the required areas of the standard, relevant to their position. A review of the HH lesson plan demonstrates all the required areas are covered. All staff interviewed indicated that they received the required PREA training. A review of documentation and staff interviews confirmed compliance to this standard.

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.

Facility policy 700.24 requires compliance to all aspects of this standard. During the past year the contractor and all volunteers received training relevant to their responsibilities under the PREA (zero-tolerance, detection, prevention, response, and reporting requirements). All training is documented and was reviewed by the auditor. It was noted the one contractor enters the facility only under staff supervision. The Director was 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.

Facility policy 300.04 requires compliance to all aspects of this standard. Prior to being transferred to HH, residents received PREA training at their previous facility (a state prison). All residents receive information at the time of intake verbally, in a PREA posting and there is information provided in the resident handbook (provided to residents at the time of intake in English or Spanish). Residents are advised of how to contact the NJDOC, HH staff, the local PREA Victim Advocate and outside sources for assistance if needed. Provisions are in place to meet the needs of all limited English proficient, illiterate and disabled residents concerning this standard. There are posters throughout the facility addressing PREA issues. Residents sign an acknowledgement of having received PREA information at the time of intake. Staff and resident interviews confirmed compliance to this standard. Reviewed documentation also supports compliance to 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.

Facility policy 700.33 requires compliance to all aspects of this standard. NJDOC investigators have received approved specialized training relevant to the PREA, and will conduct investigations at HH if necessary. The NJDOC investigators have also received training provided by the NJDOC. An examination of the training records and staff interviews confirm completion of the required instruction, and compliance to 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.

This standard is not-applicable. The facility does not employ or contract for on-site medical or mental health providers.

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.

Facility policy 700.37 requires compliance to all aspects 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. A Case Manager screens 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 at high risk for sexual victimization or at risk of sexually abusing other residents would be referred to NJDOC 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 will occur within 30 days. 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.

Facility policy 700.37 requires compliance to all aspects 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 sample screening forms, which were found to be compliant with this standard. 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.

Facility policy 600.09 addresses compliance to all aspects of this standard. A review of documentation and postings indicated that there are multiple ways for residents to report sexual abuse or harassment. The facility does not house residents for civil immigration purposes. The Program Assistants, Case Managers and residents interviewed stated residents may privately report any abuse, harassment, or neglect (which would contribute to a violation of the PREA) verbally, in writing, anonymously, or from a third party. Staff will immediately take all required further action and document the information. An investigation will immediately be opened. Posters and the inmate handbook explain the reporting procedures. HH 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.

Facility policy 600.09 addresses the requirement of this standard. Residents may file a grievance, however, all allegations of sexual abuse or sexual harassment, when received by staff, would immediately be referred to the Director and would be subject to an administrative or criminal investigation. The Director would then notify the NJDOC. There are no time limits imposed for submitting a grievance regarding an allegation of sexual abuse. Residents are not required to first use an informal grievance process in order to file a formal grievance. Residents may also file a grievance directly to the NJDOC. There was one grievance filed involving a PREA related issue during the previous 12 months. Interviews with staff and residents confirmed that they were aware of the grievance procedures and how to file or respond to a grievance. Compliance with this standard was determined by staff and resident interviews and policy review.

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.

Facility policy 400.13 addresses the requirement of this standard. There is a Memorandum of Understanding (MOU) signed with the community rape crisis center that serves the Camden, NJ area. A phone number and address to this program is

provided to residents (residents are advised contact would be as confidential as possible). The rape crisis center Victim Advocate was interviewed. The auditor did discuss what services were available to residents with the Victim Advocate, who was very familiar with the program. The NJDOC may also assist inmates in providing some services. Residents could mail a letter to contact these organizations to initiate services. HH 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.

Facility policy 700.40 addresses the requirement of this standard. Third-parties are notified of reporting procedures on the NJDOC website, VOADV website, on posters in the HH visiting area and are referenced in the resident handbook. Staff and resident interviews, as well as observations, confirmed compliance to 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.

Facility policy 700.33 addresses the requirement 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 processed and maintained confidentially. A review of policy, supporting documentation 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.

Facility policy 600.10 addresses the requirement of this standard. Staff interviewed were well aware of their duties and responsibilities, as it relates to them having knowledge of a resident being at imminent risk of being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident. They also stated they would separate the potential victim/potential predator, secure the scene to protect possible evidence, not allow residents to destroy possible evidence and contact the Program Manager. In the past 12 months, there were no instances in which the facility staff determined that a resident was subject to substantial risk of imminent sexual abuse. A review of policy/documentation and staff/resident 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.

Facility policy 700.33 addresses the requirement of this standard. Policy requires that any allegation by a resident that he was sexually abused, while confined at another facility, must be reported to the head of the facility where the alleged abuse occurred, within 72 hours of receipt of the allegation. A local investigation must also be initiated. In the past 12 months, the facility received no allegations that an inmate was abused while confined at another facility. Staff interviews confirm compliance to 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.

Facility policy 300.06 addresses the requirement of this standard. All staff interviewed were very knowledgeable concerning their first responder duties and responsibilities, upon learning that a resident may be the victim of sexual abuse. The Program Assistants and Program Manager 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. There have been no incidents within the previous year requiring first responder actions. Staff knowledge as a first responder is considered excellent. 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.

Facility policy 700.33 addresses the requirement of this standard. Documentation of compliance to this standard was reviewed by the auditor. The policy and checklist describe the coordinated actions to be taken by first responders, medical/mental health support staff outside of the facility, 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 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.

Facility policy 700.33 addresses the mandates of this standard. There is no collective bargaining agreement with employees that would be relevant to this standard, therefore, victims can be protected from abusers as stated in policy. The Director was interviewed concerning this standard, and also confirmed compliance. There was no need for this protection within the last 12 months.

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.

Facility policy 700.40 addresses the mandates of this standard. The policy prohibits any type of retaliation against any staff or resident who has reported sexual abuse, sexual harassment or cooperated in any related investigation. The PREA Manager is charged with monitoring retaliation. When interviewed, she stated she would follow up as often as necessary to ensure policy is being enforced and conduct periodic status checks on the frequency of unjust incident (discipline) reports, housing reassignments and negative performance reviews/staff job reassignments. If there was a concern that there was the potential for possible retaliation, the 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.

Not Applicable. The facility does not conduct investigations.

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 addresses the mandates of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated (NJDOC standard that applies to HH investigations).

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.

Facility policy 600.09 addresses the mandates of this standard. There was one investigation (unsubstantiated) completed within the last year that required resident notification per this standard. Policy requires notification be made to the resident pursuant to this standard, which was done. Staff interviews and a review of documentation support the finding that the facility is in compliance with this standard. The alleged victim was not available to be interviewed by the auditor.

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.

Facility policy 300.06 addresses the mandates of this standard. Staff are subject to disciplinary sanctions for violating VOADV sexual abuse or sexual harassment policies. Such discipline would be subject to the requirements of this standard. There have been no confirmed cases of inmates engaging in sex with staff. No reports were made to any licensing board or law enforcement officials pursuant to this standard. Staff interviews confirm compliance to 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.

Facility policy 300.06 addresses the mandates of this standard. Policy complies with all required actions and reporting (advising licensing boards or law enforcement officials) concerning contractors and volunteers relevant to this standard. In the past 12 months, there have not been any contractors or volunteers accused of sexual abuse or sexual harassment of a resident. Staff interviews and a review of policy confirm compliance to 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.

Facility policy 600.11 addresses the mandates of this standard. There have been no confirmed cases of staff and residents engaging in sex during the past 12 months, and no cases of other staff abuse. There were no criminal or administrative findings of guilt for resident-on-resident sexual abuse. Therapy services would be available for victims and abusers in the community (none has been requested). Policy does not allow consensual sex of any nature. Residents having sexual contact with staff will be disciplined, if it is not consensual (staff were abused). HH does not discipline residents who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with staff and a review of policy 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.

Facility policy 400.07 addresses the mandates of this standard. HH has had no resident in need of access to emergency medical or mental health treatment relevant to the PREA within the previous year. If a need occurred, the facility would ensure compliance with all actions required by this standard (free treatment, documentation of services, information about sexually transmitted diseases, confidentially). The resident would be immediately sent to a local hospital or rape crisis center where all required services will be provided. Interviews with staff, the SAFE nurse at the local hospital, the local Victim Advocate and a review of policy confirm compliance to 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.

Facility policy 400.07 outlines the mandates of this standard. The institution offers ongoing medical (in the local community or at a NJDOC facility-HH has no full time mental health or medical staff) and mental health evaluations and as appropriate, treatment to all residents who have been victimized by sexual abuse. Services are consistent with a community level of care, without financial cost to the inmate. Known resident abusers are evaluated and treatment is also offered, at no cost to the resident. A review of documentation and interviews with staff support the finding that this facility meets compliance with this standard. Interviewed residents stated they were aware of the ongoing services available under 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.

Facility policy 700.33 addresses 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. An 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 (Director), 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 and 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 corporate, mid and upper-level management. The 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.

Facility policy 700.33 addresses the mandates of this standard. The VOADV collects accurate uniform data from for every

allegation of sexual abuse at all facilities by using a standardized instrument. The data collection procedure allows the agency to submit the annual DOJ Survey of Sexual Violence in a timely fashion, prepare an annual PREA report, monitor trends, and take corrective action when indicated. The Agency aggregates and reviews all data annually, and provides the information to the NJDOC. Staff interviewed, and a review of documentation, confirmed compliance to 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.

Facility policy 700.33 addresses the mandates of this standard. The facility PREA Manager forwards required information to the Agency PREA Coordinator, who reviews the data collected to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies, and to identify problem areas and take corrective action. An Annual Report is reviewed and signed by the CEO. The Annual Report is placed on the VOADV web site. The Annual Report was reviewed by the auditor.

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.

Facility policy 700.33 addresses the mandates of this standard. The Agency PREA Coordinator reviews data (incident-based and aggregated) compiled by the facility PREA Manager and issues a report to the CEO on an annual basis. The data is retained in a secure file (over 10 years), and what is disclosable is published on the VOADV web site. The report covers all data required by 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 — August 29, 2016

Auditor Signature — Date