

# Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim       Final

**Date of Report**    December 31, 2018

## Auditor Information

<b>Name:</b> Sharon G. Robertson	<b>Email:</b> sharongr@bellsouth.net
<b>Company Name:</b> PREA Auditors of America, LLC	
<b>Mailing Address:</b> P.O. Box 10	<b>City, State, Zip:</b> Linville Falls, NC 28647
<b>Telephone:</b> 828-765-8180	<b>Date of Facility Visit:</b> April 23-24, 2018

## Agency Information

<b>Name of Agency</b>		<b>Governing Authority or Parent Agency (If Applicable)</b>	
Office of Youth Services		Department of Human Services	
<b>Physical Address:</b> 707 Richards Street, Suite 525		<b>City, State, Zip:</b> Honolulu, Hawaii 96813	
<b>Mailing Address:</b> 707 Richards Street, Suite 525		<b>City, State, Zip:</b> Honolulu, Hawaii 96813	
<b>Telephone:</b> 808-587-5700		<b>Is Agency accredited by any organization?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>The Agency Is:</b>		<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Private not for Profit
<b>Agency mission:</b> <i>To provide programs and services for Hawaii's youth including the provision of balanced and comprehensive services for at-risk youth, to prevent delinquency, reduce recidivism, and maximize opportunities for youth to become productive, responsible citizens through community based and family-focused treatment interventions.</i>			
<b>Agency Website with PREA Information:</b> <a href="http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility">http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility</a>			

## Agency Chief Executive Officer

<b>Name:</b> Merton Chinen	<b>Title:</b> Executive Director
<b>Email:</b> mchinen@dhs.hawaii.gov	<b>Telephone:</b> 808-587-5712

## Agency-Wide PREA Coordinator

<b>Name:</b> Richard Mello	<b>Title:</b> Deputy Administrator/PREA Coordinator
<b>Email:</b> rmello@dhs.hawaii.gov	<b>Telephone:</b> 808-266-9531
<b>PREA Coordinator Reports to:</b> Youth Facility Administrator	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 1

## Facility Information

<b>Name of Facility:</b> Hawaii Youth Correctional Facility	
<b>Physical Address:</b> 42-470 Kalaniana'ole Hwy, Kailua, Hawaii 96734	
<b>Mailing Address (if different than above):</b> <a href="#">Click or tap here to enter text.</a>	
<b>Telephone Number:</b> 808-266-9500	
<b>The Facility Is:</b>	<input type="checkbox"/> Military <input type="checkbox"/> Private for Profit <input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County <input checked="" type="checkbox"/> State <input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Detention <input checked="" type="checkbox"/> Correction <input type="checkbox"/> Intake <input type="checkbox"/> Other
<b>Facility Mission:</b>	
<b>Facility Website with PREA Information:</b> <a href="http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility">http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility</a>	
<b>Is this facility accredited by any other organization?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

### Facility Administrator/Superintendent

<b>Name:</b> Mark Patterson	<b>Title:</b> Youth Facility Administrator (YFA)
<b>Email:</b> mpatterson@dhs.hawaii.gov	<b>Telephone:</b> 808-266-9514

### Facility PREA Compliance Manager

<b>Name:</b> Eric Yamagishi	<b>Title:</b> Corrections Supervisor I
<b>Email:</b> eyamagishi@dhs.hawaii.gov	<b>Telephone:</b> 808-497-1684

### Facility Health Service Administrator

<b>Name:</b> Cindy Enos	<b>Title:</b> RN IV
<b>Email:</b> cenos@dhs.hawaii.gov	<b>Telephone:</b> 808-266-9525

### Facility Characteristics

<b>Designated Facility Capacity:</b> 30 + 2	<b>Current Population of Facility:</b> 23
<b>Number of residents admitted to facility during the past 12 months</b>	34
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:</b>	33
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</b>	33
<b>Number of residents on date of audit who were admitted to facility prior to August 20, 2012:</b>	0
<b>Age Range of Population:</b>	12 - 19
<b>Average length of stay or time under supervision:</b>	10-12 months
<b>Facility Security Level:</b>	2

<b>Resident Custody Levels:</b>	Max; Close; Medium; Minimum, Community
<b>Number of staff currently employed by the facility who may have contact with residents:</b>	83
<b>Number of staff hired by the facility during the past 12 months who may have contact with residents:</b>	2
<b>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</b>	11
<b>Physical Plant</b>	
<b>Number of Buildings:</b> 14	<b>Number of Single Cell Housing Units:</b> 3
<b>Number of Multiple Occupancy Cell Housing Units:</b>	0
<b>Number of Open Bay/Dorm Housing Units:</b>	0
<b>Number of Segregation Cells (Administrative and Disciplinary):</b>	2
<b>Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):</b> The facility currently utilizes approximately 41 video cameras, most of them are analog cameras, and recently upgraded their CCTV system at the Secured Custody Facility from an analog system to a digital high definition system. Cameras are located in all three housing cottages, gymnasium, classroom hallways, administration building hallways; medical visitation area; courtyard located inside secured area, service yard, and along the outside of the Secured Custody Facility. Cameras are also located along the outside of Hookipa Mauka (O&A) Building where the female residents were housed in the past. Cameras are monitored by two supervisor staff members 24/7 in Central Control located in the Secure Custody building. There are no cameras in the Vocational Training/Maintenance Building and Barn where residents are supervised by correctional staff and programs staff.	
<b>Medical</b>	
<b>Type of Medical Facility:</b>	Clinic; Off-site at Children's Hospital
<b>Forensic sexual assault medical exams are conducted at:</b>	Kapi'olani Medical Center for Women and Children
<b>Other</b>	
<b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b>	12 Contractors 42 Volunteers
<b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>	1

# Audit Findings

## Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of the Hawaii Correctional Youth Facility (HYCF) located in Kailua, Hawaii, was conducted on April 23-25, 2018 by Sharon G. Robertson from Linville Falls, North Carolina, a U.S. Department of Justice (DOJ) Certified PREA Auditor for Juvenile Facilities, working as a contractor for PREA Auditors of America, LLC. This is HYCF's first PREA audit since the implementation of the PREA standards on August 20, 2013. Audit notices were posted throughout the facility in all areas where residents, staff, volunteers, contractors, and visitors to the facility could be viewed by March 1, 2018, more than seven weeks prior to the on-site audit review and photographic evidence was submitted to the Auditor demonstrating the timely posting of the Notices. The facility was requested and agreed to keep all Notices posted for three weeks after the on-site audit review. Posted Audit Notices were observed by the Auditor throughout the facility during the on-site audit. As of the date of this report, the Auditor has not received any correspondence or mail at the PREA Auditors of America Post Office box.

The HYCF staff was requested to complete the *Pre-Audit Questionnaire* and it was provided to the Auditor, along with supporting documents in the weeks preceding the on-site review portion of the audit. The facility provided three updates to their initial response to the *Pre-Audit Questionnaire*. Pre-audit preparation included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed and revised *Pre-Audit Questionnaire*. The documentation reviewed included agency policies, including HYCF PREA policies as set forth in Chapter 12, *Youth Rights and Remedies; Subject: Prison Rape Elimination Act (PREA)*, effective September 23, 2016, hereinafter referred to in the audit report as "HYCF P&P 12.12.(relevant subsection)", procedures, forms, contracts, education materials, training certification, organizational charts, posters, brochures, and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The review prompted a series of questions that were reduced in writing and submitted to the PREA Coordinator in the form of three *Deficiencies Lists* to which responses were requested, and answered by the PREA Coordinator in the weeks before the on-site portion of the audit. The same were reviewed by the Auditor prior to the on-site review. Days prior to the on-site audit the Auditor was provided a roster of staff and residents, and notified HYCF the names of the random staff and residents selected by the Auditor for interview.

On the morning of April 23, 2018, the Auditor conducted an entrance conference with the Executive Director of the Office of Youth Services, the Deputy Facilities Administrator who is also the PREA Coordinator, the Social Workers, the Building Maintenance Supervisor, the T/A Operations Superintendent, and the Correctional Supervisor 1 for the 2nd Watch. The Youth Facilities Administrator was unable to attend the meeting as his presence was needed at the legislative session that morning. The discussion focused on the purpose of the PREA audit, an overview of the PREA process, and the schedule.

Following the entrance meeting, the Auditor toured the physical plant escorted by the PREA Coordinator, the Executive Director, the Building Maintenance Supervisor, and the Corrections Supervisor 1. The tour started in the Secured Custody Facility which houses the administrative areas, conference room, reception area, staff lounge, medical area, three isolation/holding cells; sally port; mental health offices; central control; outdoor courtyard; school programs classrooms and hallways areas; gymnasium; male housing Cottages B and C; female housing Cottage A; service area; kitchen; and staff kitchen area. The Auditor was then taken to and toured the following areas: outside perimeter and sally port; Building #2 Barn; aquaculture building which is used for storage; hydroponics building which is not functional; Mental Health staff office which is staff only; Building #4 Maluhia which has three single cells used for Sunday family visitation purposes and adjoins the living residence for the Youth Facilities Administrator; Buildings #13 and #15 which are both abandoned; Building #8 which is the old gymnasium utilized only by the female residents and an outside academics program; Building #9 Canoe House which is used for staff training; Vocational Training/Maintenance Building #11 where residents received vocational training and are supervised by security staff and vocational staff; Building #10 which is used as a storeroom; and the outdoor pool area, which was empty and is seldom utilized. During tour of the physical plant the Auditor spoke informally with staff and residents, and paid particular attention to the video

monitoring capabilities; mirror locations; potential blind spots; location of PREA posters and other PREA information; location of PREA boxes; location of grievance boxes; and reviewed the control logs in the three housing cottages. After the tour of the physical plant the Auditor began interviewing random and specialized staff and file review for the remainder of the day.

On April 24, 2018, the Auditor continued interview of staff before leaving for Honolulu to conduct specialized staff interviews and review of files. The Auditor interviewed the Executive Director, the Youth Facilities Administrator, the Investigator/Grievance Officer, Human Resources staff, the Contractor Administrator, contractor and volunteers and conducted review of personnel files, investigation records, and grievances for the past two years while in the Office of Youth Services offices in Honolulu, Hawaii. Upon return back to the facility the Auditor completed the specialized staff interviews and resident interviews. The Auditor conducted an exit meeting in the late afternoon with the Executive Director of Office of Youth Services, the Youth Facilities Administrator, and the Deputy Youth Facilities Administrator/PREA Coordinator. On April 25, 2018, the Auditor completed a review of the resident records.

The Auditor was provided a private conference room in the administration area of the Secured Custody Facility Building from which to work and conduct confidential staff interviews. To facilitate ease of movement, resident interviews were conducted in a programs room located in each cottage where the resident and Auditor could speak privately and confidentially. Resident files were reviewed in the file room in a confidential setting.

On April 24, 2018, the first day of the audit, there were 23 residents housed at HYCF (3 females and 20 males). Residents were interviewed by the Auditor on the second day. The Auditor spoke with five residents, four males and one female, from all three housing cottages who have been housed at the facility from two months to five months. Residents were interviewed using the recommended DOJ protocols that question their general and specific knowledge of a variety of PREA protections and reporting mechanisms available to residents to report abuse or harassment. On the dates of the on-site audit, there were no residents being housed with physical disabilities; who were deaf, blind or hard of hearing; who have Limited English Proficiency; who had cognitive disability; and who had been identified as LGBTQI, or had reported sexual abuse to their Social Worker. At the time of the on-site audit, there were no residents currently housed in isolation and there were no residents on-site who had previously been housed in isolation at HYCF.

A total of 31 facility and agency staff were interviewed during the on-site audit. This includes 12 random Youth Correctional Officers (YCOs) from 1<sup>st</sup> watch (10PM-6AM), 2<sup>nd</sup> watch (6AM-2PM), and 3<sup>rd</sup> watch (2PM-10:00PM); and specialty staff including medical, mental health, Social Workers (who conduct intake and risk screening), intermediate and higher level staff, first responder, agency contract administrator, investigator, education staff, human resources staff, staff who supervise residents in isolation, members of the sexual assault incident review team, and staff who monitors retaliation. Most of the staff and specialty staff interviews occurred in the facility conference room, and some of the specialty staff interviews occurred in a conference room at the Office of Youth Services in Honolulu as mentioned above. Also interviewed were the Executive Director of the Office of Youth Services, the Youth Facilities Administrator, the Deputy Youth Facilities Administrator who also serves as the PREA Coordinator, and the PREA Compliance Manager. Three contractors and two volunteers were interviewed by the Auditor. All staff, contractors and volunteers were interviewed using the recommended DOJ protocols that provides information regarding their PREA training, overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to staff and residents, the facility's response protocols when a resident alleges abuse, first responder duties, data collection processes, and other pertinent PREA requirements.

The Auditor reviewed personnel files for seven staff members to determine compliance with training mandates and background check procedures. The files for five residents currently being held in the facility were reviewed to evaluate the screening and intake procedure, resident education, and other general program areas.

The Auditor spoke by telephone with the Supervisor Analyst for the Hawaii Ombudsman's office to discuss and confirm they will receive complaints from HYCF about sexual abuse and sexual harassment, they would take anonymous reports, and their reporting procedures once they receive a complaint about sexual abuse and sexual harassment. The Auditor

also called the Sexual Abuse Hotline verifying that the telephone number provided by the facility was an accurate number and that they would receive reports about sexual abuse and sexual harassment from residents and staff. The Auditor also spoke by telephone with the Associate Director of the Sex Abuse Treatment Center (SATC) of the Kapi'olani Medical Center for Women & Children to discuss and confirm the agreement in place with HYCF to provide rape crisis intervention services, forensic medical exams by SAFE physician medical staff, assistance in the development of treatment plans, and providing outside emotional support to victims and rape advocacy services.

During the on-site tour of the physical plant the Auditor observed, among other things, facility configuration, location of cameras and mirrors; staff supervision of residents in the housing cottages and in program areas; cottage layouts including location of toilets and showers; location of telephones; placement and location of PREA posters and other PREA information; location of PREA boxes; location of grievance boxes; and security monitoring. The Auditor noted that residents shower separately from each other behind a solid closed door. Residents are housed separately in single cells that contain toilet facilities. Numerous Notices of the PREA Audit were posted throughout the facility and common areas, including the program buildings separate from the Secured Custody Facility.

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

The Auditor conducted an exit conference with agency and facility office on Tuesday evening, April 24, 2018, with the Executive Director of the Office of Youth Services, the Youth Facilities Administrator, and the Deputy Youth Facilities Administrator/PREA Coordinator. Administration and leadership were very open and receptive to an honest discussion of areas where PREA compliance and training needs to be strengthened.

## Facility Characteristics

The Office of Youth Services of the Hawaii Department of Human Services operates the Hawaii Youth Correctional Facility located at 42-470 Kalaniana'ole Highway, in Kailua, Hawaii. The Hawaii Youth Correctional Facility, a co-ed facility, is the only secure youth facility for Hawaii and receives youths from all the Hawaiian Islands. The Office of Youth Services, Department of Human Services, is regulated by Hawaii Statutes Chapter § 352 and § 352D.

The facility is located on a 550+ acre parcel of land with 17 buildings located. There are three housing areas, called Cottages A, B and C, that houses 10 residents in each cottage located along the northern and western side of the Secured Custody Facility. Male and female residents are housed separately. Additionally, there are 2 segregation/isolation rooms across from Central Control, which is located in Secured Custody Facility. School programs are located in Secure Custody Facility building along the eastern side, consisting of classrooms, a library, and a computer room. The gymnasium is located in the northeast corner of the Secured Custody Facility building. The service yard and kitchen facility are located along the southern wall near the entrance. Food is transported from the kitchen area to the Cottages and residents eat in their housing area. Medical and mental health offices and examination rooms are located adjacent to the administration offices Secured Custody Facility building. Residents are escorted by security staff to the Barn and Vocational Training/Maintenance building for additional education and vocational programs such as wood shop, welding and automotive. Security staff remains with the residents at all times when residents are out of the housing cottages during all education and programs.

There are six buildings that are used for storage or are not functional, with some in disrepair. Some of the buildings in disrepair are listed on The National Historic Registry. The old gym building is currently being used by the females and an outside alternative school. The outdoor pool area was empty and is seldom used. The facility currently utilizes approximately 41 video cameras, most of them are analog cameras, and recently upgraded their CCTV system at the Secured Custody Facility building from an analog system to a digital high definition system. The Auditor observed the placement of cameras throughout the facility during the on-site audit, and observed that all cameras were in working

order in Central Control. There are no cameras in the Vocational Training/Maintenance building or the Barn. The Auditor was informed and observed that residents were accompanied by security staff when residents are utilizing these buildings and additional supervision by non-custody program staff. Supervisory staff monitors the video cameras in Central Control located in the Secure Custody Facility building.

All doors in the Secured Custody Facility are locked and/or controlled by Central Control and key access. No residents are allowed in the buildings used for storage or abandoned. Residents are transported by security staff from their housing cottages for their classes in the Vocational Training/Maintenance building and Barn. Security staff remains with the residents until they return back to their cottage.

The maximum capacity for HYCF is 32 residents ranging in the ages from 12 to 19 with an average length of stay being approximately 10 to 12 months. The facility is co-ed and the only secured custody facility for youths in Hawaii and receive youths from all of the Hawaiian Islands. In the past 12 months the facility has admitted 33 residents whose length of stay was over 72 hours. The facility has approximately 83 staff members, two of which were hired within the past 12 months. There are 12 contractors and 42 volunteers that are authorized to have contact with the residents.

HYCF works closely with the courts and the Office of Youth Services to ensure that any commitment to HYCF is a “last resort” – after all community-based services have been exhausted. Identification of community-based programs as alternatives to incarceration is on-going. HYCF provided a variety of rehabilitative opportunities, counseling, treatment, and educational services thin the facility to aid in the redirection and rehabilitation of each resident, including transitional services for youth exiting HYCF. These programs assist with population control and help reduce recidivism by better preparing youth for adult life in the community.

## Summary of Audit Findings

This was HYCF’s first PREA audit since the implementation of the PREA standards on August 20, 2013. During the past 12 months HYCF reported in the Pre-Audit Questionnaire responses there were four allegations of sexual abuse in the facility. The Auditor reviewed the administrative investigation files of these incidents and spoke with the Investigator checking for sufficiency and compliance with the PREA standards.

Interviews and informal interaction with the residents reflected that they are aware of and understand the PREA protections, the agency’s zero-tolerance policy, and ways to make reports. Along with their Social Worker, residents review the (1) PREA Orientation Form; (2) *End the Silence: Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)*; (3) how to avoid risky situations; (4) Internal Communication Form on Zero Tolerance and Fraternalization; (5) shown the a PREA video presentation; and (6) provided with a copy of the HYCF Youth Handbook with PREA Orientation supplemental information such as the *End the Silence* Comic Books series. Residents indicated they were aware of PREA posters located throughout the facility, and were able to articulate to the Auditor what they would do and who they would tell if they were sexually abused. Residents indicated to the Auditor they were safe at HYCF. The agency and facility provides the names and contact information for a multiple agencies and advocacy services for residents, staff and third-parties to report sexual abuse and sexual harassment in the resident handbook, parent handbook, and on their website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility>.

All staff could articulate the meaning of the agency’s zero-tolerance for sexual abuse and sexual harassment. All staff stated they have not received any detailed PREA training. Staff was knowledgeable about their roles and responsibilities in the prevention, reporting, and first responder duties; however, staff also stated they were going by other protocols (i.e., use of force or suicides), and their instincts from basic correctional staff training. The facility has not developed a first responder protocol for staff, contractor, and volunteers to follow; and has not developed a written plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The agency and facility have complied with some of the data collection and review standard, and will need to develop a protocol to improve their sexual incident reviews. Sexual

abuse incidents have happened at this facility and it is important to provide training and practice of the protocols through training events or mock drills to maintain the skill set of first responders and a coordinated response.

In summary, after reviewing all pertinent information, documentation, and conducting the on-site audit tour, resident interviews, and staff interviews, the Auditor found that the agency leadership and facility leadership have made PREA compliance a priority and have devoted a significant amount of time and resources to policy development and education of residents. Discussions with agency leadership and facility management reinforced the agency's commitment to ensuring the safety of residents and staff at HYCF against sexual abuse and sexual harassment. There are significant areas of compliance noted in this interim report that will require strengthening through corrective action as detailed in this interim report. The interim status of standards that were exceeded, met, or not met is detailed below. There are a total of 43 standards, having between 1-10 subsections. To achieve compliance of any given standard, the facility must achieve 100% compliance with each and every subsection within the Standard as set forth in this report. The compliance performance is shown in this Interim 2018 PREA Audit Report dated May 15, 2018.

### PREA Standards Compliance Overview – Interim Audit Report

**Number of Standards Exceeded:** 4

- §115.316;
- §115.333
- §115.351; §115.354

**Number of Standards Met:** 25

- §115.312; §115.317; §115.318;
- §115.334; §115.335
- §115.341; §115.342;
- §115.352; §115.353;
- §115.361; §115.362; §115.363; §115.366; §115.367; §115.368;
- §115.371; §115.372; §115.373;
- §115.376; §115.377; §115.378;
- §115.381; §115.382; §115.383;
- §115.403;

**Number of Standards Not Met:** 14

- §115.311; §115.313; §115.315;
- §115.321; §115.322;
- §115.331; §115.332;
- §115.364; §115.365;
- §115.386; §115.387; §115.388; §115.389;
- §115.401;

**Total Standards:** 43



## Summary of Corrective Action Taken to Achieve Full Compliance

The Interim Audit Report reflected that there were 14 Standards that were in non-compliance at the Hawaii Correctional Youth Facility (HYCF). Therefore, a corrective action period not to exceed 180 days began on June 11, 2018. The Auditor recommended corrective actions for the facility and administration agreed and began immediate corrections of those Standards found to be in non-compliance. HYCF administration worked diligently to bring the facility, staff, volunteers and contractors in compliance during the corrective action period.

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

### PREA Standards Compliance Overview – Final Audit Report

**Number of Standards Exceeded:** 4

- §115.316;
- §115.333
- §115.351; §115.354

**Number of Standards Met:** 39

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

**Total Standards:** 43

# PREVENTION PLANNING

## Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?  Yes  No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?  Yes  No

### 115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator?  Yes  No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy?  Yes  No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?  Yes  No

### 115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)  Yes  No  NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)  
 Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.2, 12.12.3 and 12.12.4.1 and 12.12.4.2
3. Department of Human Services Internal Communications Memo to All HYCF Staff, dated October 9, 2015, Subject: Zero Tolerance
4. Agency Organizational Chart and HYCF Organizational Chart
5. Interviews with the following:

- a. PREA Coordinator
- b. PREA Compliance Manager

### **Findings (By Subsection):**

Subsection (a): HYCF has a comprehensive policy on sexual abuse and sexual harassment contained in Chapter 12.12, entitled, *Youth Rights and Remedies*, Subject: Prison Rape Elimination Act (PREA), effective September 23, 2016 (“HYCF P&P”). The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy details definitions that are compliant with the PREA definitions. The policy further outlines the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment; and detailed employee corrective actions and disciplinary sanctions for conduct that meets the definition of sexual abuse and harassment. The agency also issued Department of Human Services Internal Communications Memo (“ICF”) to All HYCF Staff, dated October 9, 2015, Subject: Zero Tolerance, stating that, “OYS/HYCF has implemented a zero-tolerance policy concerning all forms of sexual abuse and sexual harassment towards: (1) a youth by another youth; or (2) a staff member on a youth, in any HYCF facilities and any contracted facilities operating under direct control or under contract. All references to staff members will include contractors and volunteers to include interns paid or donate time and services.” A copy of this ICF is available to the public on the website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>.

Subsection (b): The agency has designated Richard Mello as the PREA Coordinator. Mr. Mello is the Deputy Youth Facilities Administrator (“Deputy YFA”) and reports directly to Mark Patterson, the Youth Facility Administrator (“YFA”), who reports directly to the Executive Director of the Office of Youth Services (“OYS”) under the Hawaii Department of Human Services. Mr. Mello is part of the upper management team at HYCF. During the on-site audit, Mr. Mello reported to the Auditor that he does not have sufficient time and authority to develop, implement and oversee the agency’s efforts to comply with the PREA Standards and has discussed this with the YFA.

Subsection (c): Even though OYS operates only one facility, Eric Yamagishi has been designated as the PREA Compliance Manager. Mr. Yamagishi is a Corrections Supervisor I (“CS1”) and reports directly to the Deputy YFA, who is also the PREA Coordinator at HYCF. During the on-site audit, Mr. Yamagishi reported to the Auditor that he does not have sufficient time to develop, implement and oversee the agency’s efforts to comply with PREA; that he has received no training and had to learn his PREA responsibilities on his own; and there has been no communication between him and the PREA Coordinator. The PREA Coordinator reviews and coordinates the facility’s efforts to comply with the PREA Standards. Mr. Yamagishi stated he does receive some assignments from the PREA Coordinator.

### **Corrective Action:**

1. HYCF must ensure that the PREA Coordinator has sufficient time and authority to develop, implement and oversee the Agency’s efforts to comply with the PREA Standards and as set forth in this Standard and HYCF P&P 12.12.4.2(a).
2. HYCF must ensure that the PREA Coordinator has sufficient time and authority to develop, implement and oversee the Agency’s efforts to comply with the PREA Standards and as set forth in HYCF P&P 12.12.4.2(b).
3. If HYCF continues to utilize a PREA Compliance Manager, HYCF must ensure that the PREA Compliance Manager has sufficient time and authority to coordinate the facility’s efforts to comply with the PREA Standards and as set forth in HYCF P&P 12.12.4.2(b) and provide training to ensure comprehension and working knowledge of his as PREA Compliance Manager.
4. Documentation showing compliance with this Standard must be submitted to the Auditor.

### **Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on December 10, 2018 to evidence and demonstrate corrective action taken by OYS and HYCF administration regarding this standard. This documentation is discussed below.

### Additional Documentation Reviewed:

1. The Auditor interviewed the PREA Coordinator by telephone on December 10, 2018, and was told that he now has sufficient time and authority to develop, implement and oversee the Agency's efforts to comply with the PREA Standards and as set forth in HYCF P&P 12.12.4.2.
2. The Auditor was also informed during this interview that the position of PREA Compliance Manager has been eliminated because the agency only one facility.
3. The Auditor was provided documentation showing that OYS is working with officials in the State of Hawaii Human Resources in creating a permanent PREA Coordinator position with OYS.

Based on additional documentation and telephonic interviews with the PREA Coordinator, YFA and OYS Executive Director, this standard is now fully compliant and the facility meets this standard.

## Standard 115.312: Contracting with other entities for the confinement of residents

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)  Yes  No  NA

#### 115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.3, *et. seq.*
3. Interviews with the following:
  - a. PREA Coordinator
  - b. Agency Executive Director

## Findings (By Subsection):

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

**Subsection (b):** The agency has a policy requiring any new contracts or contract renewals with private agencies or other entities for the confinement of HYCF's residents to adopt and comply with the PREA standards, and subject to HYCF monitoring/audits as part of its contract with the Agency to ensure compliance with PREA standards.

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

**Corrective Action:** None.

## Standard 115.313: Supervision and monitoring

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?  Yes  No

- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated)?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?  Yes  No

#### 115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?  Yes  No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.)  Yes  No  NA

#### 115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances?  Yes  No
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances?  Yes  No
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios?  Yes  No
- Does the facility ensure only security staff are included when calculating these ratios?  Yes  No
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?  Yes  No

#### 115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?  Yes  No

### 115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)  Yes  No  NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)  Yes  No  NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.4, *et seq.*
3. HYCF Staffing Plan, dated May 16, 2017
4. Cottage/Unit Log Book and Central Control Log Book and HYCF Physical Plan Vulnerability Assessment Form for unannounced rounds
5. HYCF Administrator's Shift Report Daily Minimal Staff Cottage reports for February 1, 2017 thru January 31, 2018
6. Interviews with the following:
  - a. Youth Facility Administrator
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Immediate or Higher Level Facility Staff – Correctional Supervisors 1
  - e. Agency Executive Director

## Findings (By Subsection):

Subsection (a): Pursuant to HYCF policy the agency has developed a Staffing Plan for HYCF, which briefly discusses all 11 required elements in this standard. The facility reported in the PAQ the average daily number of residents was 46, and the Staffing Plan is predicated for an average daily number of 46 residents. As of April 23, 2018, the first day of the on-site audit, there were 23 co-ed residents housed and a total of 24 staff (5 on 1<sup>st</sup> Watch (10PM-6AM), 8 on 2<sup>nd</sup> Watch (6AM-2PM, and 11 on 3<sup>rd</sup> Watch (2PM-10:00PM) on duty. The Auditor was provided and reviewed the Staffing Plan, dated May 16, 2017. The review included consideration of the physical plant, location of blind spots, staffing levels, prevailing staffing patterns, video monitoring to protect residents against abuse, and the allocation of agency and facility resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility has a video monitoring system, which includes 41 video cameras, of which 9 are high definition cameras, that monitors the majority of the interior and exterior of the secure custody facility. The CCTV system was completed in December 2017 and included digital high definition system with a new digital DVR which automatically records and is available for use in post-incident investigations or their review of a particular time and location. The video system is actively monitored 24/7 via screen in Central Control by CS1 and Youth Correctional Supervisors ("YCS"). Interviews with the YFA, the agency director, and the PREA Coordinator confirmed compliance with PREA standards, and that safety and security procedures are the primary focus when considering staffing patterns and video monitoring. As part of the PAQ, the Auditor was provided documentation showing that the CS1 is not randomly monitoring the video cameras during 1<sup>st</sup> Watch, which are the hours from 10:00PM to 6:00AM. During the on-site audit the PREA Coordinator stated that the CS1 has started monitoring the video cameras. The YFA stated that during working hours there are corrections staff, known as Youth Corrections Officer ("YCO"), one YCS to manage the security of the facility, and CS1 to supervise the entire and all non – security staff. Additional, the YFA lives on the facility grounds and is available for emergency contact. The YFA stated that he has closed some buildings that were old and had blind spots have been closed, and YCO always accompany any residents when they leave the cottage housing unit; and staff are always inside the school rooms and other programs supervising residents along with school and program staff. The YFA further stated that video monitoring is not the primary source of supervision; however, it is used as a means of monitoring, detecting, and protecting residents and staff and a ways of holding people accountable.

Subsection (b): HYCF policy and the Staffing Plan requires deviations to be documented in the Cottage/Unit Log and Central Control Log, and the completion of the HYCF 200 Incident form for every instance of deviation that is to be submitted to the PREA Coordinator by the end of the shift in the PREA designated locked box at Central Control. The facility reported in the PAQ there have been no deviations to the staffing plan for the past 12 months. The PREA Coordinator/DYFA stated that he utilizes over-time to make sure there is enough staff working during all watches.

Subsection (c): The facility reported on the PAQ they have maintained a minimum staffing ratio of 1:8 during resident waking hours and a minimum staffing ratio of 1:16 during resident sleeping hours, and there have been no deviations to the staffing ratio for the past 12 months. A review of the Daily Minimal Staff Coverage showed that the facility maintained a higher staffing ratio than required by this standard for waking and sleeping hours. The YFA and PREA Coordinator/Deputy YFA stated that they utilize over-time to make sure there is enough staff working during all watches. The YFA stated there is a report generated for every watch stating the names of the staff persons who worked the names of anyone who was called in to work overtime, and the positions where they were assigned. This report is reviewed by the YCS, CS1 and Deputy FYA. There are female-gender postings in the female cottages requiring a percentage of female staff on duty during all watches, and the facility will move a supervisor into an unfilled female position if necessary.

Subsection (d): HYCF policy requires the staffing plan to be reviewed annually for the four required elements in this standard. The Staffing Plan states that the plan will be reviewed quarterly by the YFA in concert with the PREA Coordinator and Manager, and the staffing plan review is to be documented and recommendations for any revisions, additions, or deletions implemented in a timely fashion. During the pre-audit, the Auditor was informed the HYCF Staffing Plan, dated May 16, 2017, and was reviewed by the YFA and Deputy YFA when it was implemented. The Auditor



was also informed that there is no documentation showing the Staffing Plan has undergone the annual review in July of 2017, and any quarterly review as required by HYCF P&P 12.12.4.4(d) since its implementation on May 16, 2017.

Subsection (e): HYCF policy states that correctional supervisors conduct and document unannounced rounds on all three watches which are documented in the housing unit Log Book, Central Control Log Book and HYCF Physical Plant Vulnerability Assessment Form. The HYCF Staffing Plan states that the Deputy YFA and YFA shall make unannounced rounds at least once a month, the CS1 make unannounced rounds of each living unit at least once a week, and YCS make unannounced rounds at least once a day. The Auditor was provided a random sample for each month of the documented unannounced rounds conducted by the Deputy YFA during all three watches; however, there was no documentation for the CS1 and YCS as required by the HYCF Staffing Plan. During the on-site audit, the Auditor viewed the housing unit Log Book in all three housing cottage and the Central Control Log Book further verifying that information provided to the Auditor was correct and that unannounced rounds are being conducted and documented during all watches by upper management. The Auditor was informed by CS1 that he enters all three housing cottages every day performing unannounced rounds; however, they are not documented because he was not aware they were supposed to be documenting their rounds in the log book.

#### **Corrective Action:**

1. HYCF must ensure that CS1 is monitoring the video cameras during the 1<sup>st</sup> Watch and provide documentation to the Auditor.
2. HYCF must document the quarterly reviews and annual review of the staffing plan as conducted by the YFA and PREA Coordinator pursuant to HYCF P&P 12.12.4.4(d) and subsection (d) of this Standard, and provide documentation of this review to the Auditor.
3. HYCF must document the unannounced rounds conducted by the CS1 and YCS pursuant to the HYCF Staffing Plan, HYCF P&P 12.12.4.4(e), and subsection (e) of this Standard. Documentation showing compliance with this Standard must be submitted to the Auditor.

#### **Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 2, 2018 and during telephonic interviews on December 5 and 10, 2018, to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

#### **Additional Documentation Reviewed:**

1. During telephonic meetings on August 2, 2018 and December 5 and 10, 2018, the Auditor was informed that a YCS is actually the person in charge of the 1st Watch and that the position is not held by a CS1. The YCS of the First Watch 1 is monitoring the video system during the night.
2. Telephonic confirmation by DYFA and CS1 regarding quarterly meeting reviewing the staff plan compliance with this standard and their policy.
3. Development of HYCF Form 404, YCS Daily/Shift Unannounced Round Log for utilization by YCS during daily unannounced rounds in all three housing modules showing date and time of unannounced round, initials of the person making the rounds, and notes, and name of CS1 reviewing and verifying module log entries.
4. Telephonic interviews and completed HYCF Form 404 from November 10 – 30, 2018 showing that YCS are documenting their daily unannounced rounds utilizing HYCF Form 404.

HYCF held a meeting on August 29, 2018, where the YFA, PREA Coordinator, and other HYCF staff met quarterly to discuss the HYCF Staffing Plan. This was confirmed during telephonic interviews with HYCF specialized staff on December 5 and 10, 2018. The facility has implemented a procedure for YCS staff on 1st Watch to monitor the video system. The Auditor was also provided copies of the daily completed HYCF Form 404 completed by YCS staff for the period of November 10 – 30, 2018 for review verifying that unannounced rounds are being completed and documented

on a daily basis during all three watches for all HYCF housing units. This standard is now fully compliant and the facility meets this standard.

## Standard 115.315: Limits to cross-gender viewing and searches

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?  Yes  No

#### 115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?  Yes  No  NA

#### 115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?  Yes  No
- Does the facility document all cross-gender pat-down searches?  Yes  No

#### 115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?  Yes  No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)  Yes  No  NA

#### 115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?  Yes  No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?  Yes  No

## 115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?  Yes  No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.5, *et seq.*
3. Hawaii Statutes Chapter §352-5 Staff Standards and Training
4. HYCF Internal Communication Form, Subject: Announcement of Cross Gender Supervision, dated July 14, 2016
5. Interviews with the following:
  - a. Random Staff
  - b. Random Residents

### Findings (By Subsection):

Subsection (a): HYCF policy addresses resident searches. The facility reported in the PAQ they do not conduct cross-gender strip searches or cross-gender visual body cavity searches of residents. In the past 12 months, there has been no cross-gender strip or visual body cavity searches performed by staff or non-medical staff. Staff interviews confirmed staff does not conduct cross-gender strip searches or visual body cavity searches of residents.

Subsection (b): HYCF policy does allow for cross-gender pat-down searches in exigent circumstances only. The facility reported in the PAQ in the past 12 months there have not been any cross-gender pat-down searches performed by staff. During staff interviews the Auditor was told they were not aware of any policy prohibiting cross-gender pat-down searches, they are not restricted from conducting cross-gender pat-down searches, and they could conduct cross-gender pat-down searches. However, many staff stated they would only perform cross-gender pat-down searches when same-sex staff is not available. It appears from staff interviews that staff may not be documenting when they perform a cross-gender pat-down search and the circumstances why they conducted the search.

Subsection (c): HYCF policy requires staff to document the incident in the Cottage log with the date, time, name of resident, name of staff conducting search and justification for the cross-gender search whenever cross-gender strip search, cross-gender visual body cavity search and cross-gender pat-down search occurs. The Cottage YCS or Assistant Youth Correctional Supervisor (“AYCS”) is also required to complete a HYCF 200 Incident Report with the same information recorded in the Cottage log book and submit through proper channels with a copy to the PREA Coordinator. During staff interviews the Auditor was told they were not aware of the policy to log any cross-gender pat-down searches as required by policy.

Subsection (d): HYCF policy prohibits staff of the opposite gender from viewing residents when showering, performing bodily functions, and changing clothing except in exigent circumstances or when viewing is incidental to routine cell checks. HYCF P&P 12.12.4.5(e) requires staff of the opposite gender to announce their presence and log this notice in the Cottage log book when entering an area where a resident is likely to be showering, performing bodily functions, or changing clothing. HYCF P&P 12.12.4.5(e)(1) states whenever a resident is placed on "Precautionary Direct Supervision" or one-to-one, the facility shall ensure that the direct supervision staff is of the same gender, except in exigent circumstances where all attempts to meet this requirement have failed. If exigent circumstances existed, staff must document the circumstances in the Central Control log in the secured lock-up cell and/or in the Cottage log for review by the CS1 to confirm exigent circumstances existed. During the on-site audit, staffs were observed announcing cross-gender presence. HYCF provides a single, private area behind a solid door allowing individual residents to use the toilet and shower in a private manner. Staff will perform a verbal health and welfare check after about three to five minutes to check on the welfare of the resident. Interviews with staff and residents indicated that staff of the opposite gender is making announcements upon entering the cottage, and the Auditor observed these announcements being made during the on-site audit.

Subsection (e): HYCF policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status, and will seek to determine the status by conversing with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Staff interviews confirmed that they were aware of the policy prohibiting searches of transgender or intersex residents for the sole purpose of determining their genital status.

Subsection (f): HYCF policy states staff are to ensure that cross-gender pat-down searches and searches of transgender and intersex offenders are conducted in a professional, respectful, and in the least intrusive manner possible, while maintaining security needs. Hawaii Statutes Chapter §352-5 states the director of HYCF shall establish written standards of conduct and operation to govern each staff member during working hours and new staff members shall undergo initial training to prepare them to comply with the standards. The facility reported in the PAQ that 0% of security staff have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Staff interviews indicated they have not received specialized training on cross-gender pat-down searches and performing pat-down searches of transgender and intersex residents.

**Corrective Action:**

1. HYCF must ensure that all staff are knowledgeable and receive training on HYCF Policy regarding cross-gender pat-down searches and that all cross-gender pat-down search must be documented include the circumstance why a cross-gender pat-down search was conducted. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.
2. HYCF must ensure that all staff are knowledgeable and receive training on how to conduct searches of transgender and intersex residents should a situation arise where the search preference of a transgender or intersex resident would indicate that a cross-gender search should be authorized. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.

**Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 3, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

**Additional Documentation Reviewed:**

1. Review of the instructional video Guidance in Cross-Gender and Transgender Pat Searches, dated February 2015, and facilitator's guide on conducting professional and respectful cross-gender pat searches and pat searches of transgender inmates as developed by The Moss Group, Inc. and PRC for training available on the PREA Resource Center website.
2. Training sign-in sheets for Training: Ethic and Professionalism, Civil Rights Awareness, PREA: Cross-Gender and Transgender Pat Search held on June 26, 2018, and July 3, 10, 17, 24 and 31, 2018 covering the cross-gender pat-down searches and searches of transgender residents.
3. The Auditor conducted telephonic interviews with 15 random staff on December 5 and 10, 2018.

HYCF has trained all staff on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional, respectful, and in the least intrusive manner possible, while maintaining security needs. All staff were able to articulate their duties as enumerated in this Standard during the telephonic interviews. This standard is now fully compliant and the facility meets this standard.

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

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.316 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)  Yes  No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?  Yes  No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?  Yes  No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?  Yes  No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision?  Yes  No

### 115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?  Yes  No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No

### 115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.6, *et seq.*
3. Department of Human Services Director's Memorandum #15-01, Opportunities to Participate in Programs and Services, dated January 12, 2015
4. Department of Human Services Director's Memorandum #17-01, Opportunities to Participate in Programs and Services, dated January 12, 2017

5. Corporate Translation Services, Inc. dba Language Link Contract (formerly CTS Linguistica) effective March 2018 to March 2019
6. DHS Form 5000 Offer and Acceptance or Waiver of Free Interpreter Services
7. Guidelines for Providing Equal Access by Removing Language Barriers and Providing Interpretation Services Script and Language Assistance Sheet in 17 languages
8. Department of Human Services Language Access Protocol
9. End Silence – Youth Speaking Up About Sexual Abuse in Custody Series and Facilitator’s Guide
10. Interviews with the following:
  - a. Agency Head
  - b. Random Staff
  - c. Social Workers

**Findings (By Subsection):**

Subsection (a): HYCF P&P 12.12.4.6(a) ensures that residents with disabilities, including those who are deaf/hard of hearing or those who are blind or visually impaired, have access to all aspects of the facility’s PREA protections. The Agency has entered into MOU with a private vendor to provide sign language interpreting services for the deaf/hearing impaired residents at no cost to the resident. The policy ensures that written materials are provided in formats and through methods that ensure effective communication with residents with disabilities, including youths who have intellectual disabilities, limited reading skills, or who are blind or have low vision. At the time of the on-site audit, there were no residents housed at the facility who were limited English proficient or who had communication disabilities.

Subsection (b): HYCF P&P 12.12.4.6(b) ensures that residents who are limited English proficient (LEP) have access to all aspects of the facility’s PREA protections, including steps to provide interpreters who can interpret effectively, accurately and impartially, any speech, pamphlet, poster, video, etc. to ensure the LEP resident is orientated to PREA. As part of the PAQ, the Auditor was provided a copy of the Corporate Translation Services, Inc., dba Language Link Contract (formerly CTS Linguistica) effective March 2018 to March 2019, that provides interpreting services, at no cost to the resident, for LEP residents in 115 languages, and copy of the sheet for the resident to identify the 17 foreign languages, including Hawaiian and other island languages, most common on the Hawaii islands.

Subsection (c): HYCF P&P 12.12.4.6(c) prohibits the use of resident interpreters, resident readers, or other types of resident assistance except in limited circumstances as authorized in this standard. The facility reported that in the past 12 months there have been no instances where resident interpreters, resident readers, or other types of resident assistants have been used. Interviews with staff members consistently revealed that resident interpreters are never used and staff could articulate why using resident interpreters is not considered a best practice.

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

**Corrective Action:** None.

**Standard 115.317: Hiring and promotion decisions**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.317 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No

#### 115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?  Yes  No

#### 115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check?  Yes  No
- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?  Yes  No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?  Yes  No

#### 115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?  Yes  No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?  Yes  No



### 115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?  Yes  No

### 115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?  Yes  No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?  Yes  No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?  Yes  No

### 115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?  Yes  No

### 115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)  
 Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.7, *et seq.*
3. Hawaii Youth Statutes Chapter §352 and Chapter §352D
4. Department of Human Services, Office of Youth Services, Hawaii Youth Correctional Facility (HYCF) Recruiting and Hiring Materials – Recruitment Process for HYCF Vacancies
5. Department of Human Services, Office of Youth Services, Hawaii Youth Correctional Facility (HYCF) Recruiting and Hiring Materials – Recertification Process for HYCF Staff

6. Department of Human Services Internal Communication Form, Subject: 2017 HYCF Annual Recertification and Prison Rape Elimination Act (PREA) of 2003 Five-year Recertification, dated November 6, 2017
7. HYCF Personnel Files for New Hires and Existing Staff
8. Contractual Agreements for 11 Vendors having contact with residents
9. Review of personnel files
10. Interviews with the following:
  - a. Agency Human Resources Staff

**Findings (By Subsection):**

Subsection (a): HYCF P&P 12.12.4.7(a) states HYCF shall not hire or promote anyone who may have contact with residents and shall not enlist the services of any contractor who may have contact with residents with the prohibitions set forth in this standard. The agency's vacancy announcements and employment applications requires applicants to answer and certify their responses to the 3 subsections outlined in this subsection of the standard. The Auditor reviewed seven random staff files for completed certification.

Subsection (b): HYCF P&P 12.12.4.7(b) states HYCF shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, that may have contact with residents. The agency's vacancy announcements and employment applications requires applicants to answer and certify their responses to this subsection of the standard.

Subsection (c): HYCF P&P 12.12.4.7(c) states before hiring new employees who may have contact with residents, HYCF shall perform background records check, consult any child abuse registry, and contact all prior institutional employers for information on allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse or sexual harassment. Hawaii General Statutes Chapter §352-5.5 and §352D-4.3 requires prospective HYCF staff to submit to comprehensive background character reference check; criminal history record clearance; adult/child protective services central registry check; and fingerprint within 5 days of employment, and name inquiry into the state and national criminal history files staff members. The agency's vacancy announcements and employment applications requires applicants to answer and certify their responses to this subsection of the standard.

The facility reported in the PDQ that in the past 12 months 2 persons were hired who had criminal background record checks conducted. The Auditor was provided a copy of completed applications requiring new hires to disclose sexual harassment or sexual abuse resigned during a pending investigation of alleged sexual abuse or sexual harassment. Interview with the Human Resources Staff confirmed that the required background checks and five-year follow-up background checks are being conducted, and the agency is contacting former employers. During the on-site audit, the Auditor reviewed seven personnel files for new hires and documentation showing that the required background checks had been conducted.

Subsection (d): HYCF P&P 12.12.4.7(c) states before hiring new contractors or volunteers who may have contact with residents, HYCF shall perform background records check, consult any child abuse registry, and contact all prior institutional employers for information on allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse or sexual harassment. Hawaii General Statutes Chapter §352D-4.3 requires prospective HYCF volunteers of contracted providers or subcontractors in positions that place them in close proximity to youth when providing services on behalf of the office shall be required to agree to criminal history record checks conducted by the office; and shall (1) submit a sworn statement indicating whether the individual has ever been convicted for offense for which incarceration is a sentencing option; (2) be subject to criminal history record checks through Hawaii criminal justice data center and annual name inquiry in the state criminal history record files; and (3) provide written consent to obtain criminal history record information for verification.

The facility reported in the PAQ that in the past 12 months 11 contracts for services where criminal background record checks were conducted on staff that might have contact with residents. The Auditor reviewed vendor contracts for 11

vendors and noticed where not all of the contracts require the needed background checks or ask questions regarding sexual abuse or sexual harassment. The contractor hiring process does not appear to solicit information about sexual harassment or sexual abuse conduct; nor does the contract renewal process consider this. During the interview with the OYS Contract Administrator the Auditor was informed: (1) that all contracts contain zero-tolerance language; (2) that all contract require background checks for all contractors; (3) that the contractor conducts the criminal background checks, including Criminal Justice Data Center and fingerprinting, and the contractor maintains copies of the criminal background checks at the contractor's office; (4) the contracts contain automatic language for termination of the employee who violates PREA standards; and (5) the OYS Contractor Administrator conducts on-site monitoring at the contractor's office to review each employee confirming that each employee has had a background check completed within the past five years and updated every five years.

Subsection (e): HYCF P&P 12.12.4.7(d) states HCYF will make its best effort to conduct criminal background record checks yearly, but shall conduct criminal background records check at least every five years of current employees, contractors and volunteers who may have contact with residents. Hawaii General Statutes Chapter §352-5.5 and §352D-4.3 requires prospective HYCF staff to submit to comprehensive background character reference check; criminal history record clearance; adult/child protective services central registry check; and fingerprint within 5 days of employment, and name inquiry into the state and national criminal history files staff members. Hawaii Revised Statutes §352-5.5 requires the department to conduct an annual name inquiry into the state criminal history record files for all HYCF staff. The Auditor reviewed Department of Human Services Internal Communication Form 2017 HYCF Annual Recertification and Prison Rape Elimination Act (PREA) of 2003 Five-year Recertification memo to HYCF Administration, dated November 6, 2017, and the Internal Memo to HYCF Employees dated November 7, 2017, requiring all staff to completed DHS Form 3003A - local criminal history record database; HRD 329-B – FBI criminal history record checks; and DHS 151 – Child Abuse and Neglect/Adult Protective Services registry checks. Staff was also fingerprinted after returning the completed forms. During the on-site audit, the Auditor verified that all employees, contractors, and volunteers who have contact with residents have had criminal background record checks completed within the past five years, and reviewed seven employee files and three contractor and volunteer files for completed background checks.

Subsection (f): HYCF P&P 12.12.4.7(f) requires HYCF staff to immediately disclose misconducted and immediately report any type of misconduct as required by this standard to the YFA through their chain of command.

Subsection (g): HYCF P&P 12.12.4.7(h) states that any HYCF staff who omits reporting or provides false information of any type of misconduct as required by this standard is subject to discipline up to and including discharge. Specialized staff interviewed stated that material omissions regarding related misconduct, or the provision of materially false information, is grounds for termination.

Subsection (h): Pursuant to HYCF P&P 12.12.4.7(h), the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving current or former employees to any institution employer conducting a background check with a signed consent to release information form.

As part of the PAQ documentation, the Auditor was provided selective portions of 5 unit agreements of the collective bargaining agreement between the Hawaii Government Employees Association and the United Public Workers, effective July 1, 2013 until June 30, 2017, related to the HYCF employees who work directly with residents. The Auditor verified with the OYS Executive Director that even though the contract has expired, it is still in effect until a new contract is approved and established. As of the date of the audit, a new agreement has not been reached and is still at an impasse. The Auditor did not find any language in the collective bargaining agreement that prohibited the agency or facility from disciplining or firing staff.

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

**Corrective Action:** None.

## Standard 115.318: Upgrades to facilities and technologies

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)  Yes  No  NA

#### 115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.8, *et seq.*
3. Interviews with the following:
  - a. Agency Head
  - b. Youth Facilities Administrator
  - c. Deputy Youth Facilities Administrator

### Findings (By Subsection):

Subsection (a): The agency has not acquired any new facility or made a substantial expansion or modification to the existing facility. The YFA stated that some older buildings with blind spots have been closed and are no longer being used.

Subsection (b): The facility reported in December 2017 they upgraded the CCTV system at the Secured Custody Facility from an analog system to a digital high definition system with a new digital DVR. The facility will be adding cameras when funds become available. The YFA stated when considering updated monitoring they are looking to provide for a safe environment for the child by looking at the safety of the environment for the resident and staff. The agency has submitted a grant proposal currently before the Governor to install a CCTV system at the Maintenance Yard to enhance supervision by direct staff and to eliminate blind spots.

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

**Corrective Action:** None.

## RESPONSIVE PLANNING

### Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  
 Yes  No  NA

#### 115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  
 Yes  No  NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  
 Yes  No  NA

#### 115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?  Yes  No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?  Yes  No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?  
 Yes  No
- Has the agency documented its efforts to provide SAFEs or SANEs?  Yes  No

### 115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?  
 Yes  No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?  Yes  No
- Has the agency documented its efforts to secure services from rape crisis centers?  Yes  No

### 115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?  Yes  No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?  Yes  No

### 115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)  Yes  No  NA

### 115.321 (g)

- Auditor is not required to audit this provision.

### 115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.9, *et seq.*

3. Memorandum of Understanding (MOU) with Sex Abuse Treatment Center (SATC) of the Kapi'olani Medical Center for Women & Children, dated September 19, 2016

4. Interviews with the following:

- a. Random Staff
- b. Investigative Staff
- c. PREA Coordinator
- d. SANE/SAFE staff

**Findings (By Subsection):**

Subsection (a): HYCF conducts administrative investigations of sexual abuse and sexual harassment. All criminal sexual abuse investigations are referred to the Honolulu Police Department. The case is referred to the Hawaii Department of Attorney General for criminal investigation if the Honolulu Police Department declines to investigate the initial report related to a criminal case.

Subsection (b): The HYCF protocol is adapted from the national protocol referenced in this standard. The Investigator received training on Sexual Assault Investigations Training in February 2017 that included practices adapted from the *National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*.

Subsection (c): HYCF does not perform sexual assault medical forensic evaluations, and offers all residents who experience sexual abuse access to forensic medical examinations, at no cost, where evidentiary or medically appropriate, at the Sex Abuse Treatment Center (SATC) of the Kapi'olani Medical Center for Women & Children Emergency Room pursuant to the MOU. HYCF first responders will stabilize the victim upon receiving a report alleging sexual abuse and/or assault, and use best efforts to preserve forensic evidence while assisting the victim. HYCF reported in the PAQ that there have been no forensic medical exams conducted or performed by SANEs/SAFEs staff or qualified medical practitioner within the past 12 months. The Auditor verified through telephone conversation with the Associate Director of SATC that the MOU is currently in effect; they provide SAFE medical physicians, including a pediatric physician specializing in medical care for those age 13 and an adolescent physician for those age 14 and above, who are available on-call if not in the ER at the time the resident is brought in.

Subsection (d): SATC utilizes victim advocates and HYCF Health Care and Family Court Liaison Branch (FCLB) Mental Health practitioners follow-up on the prescribed treatment plan or develop a treatment plan. Pursuant to the MOU with SATC, which is in full force and effect until amended or terminated by either party upon 30 calendar day written notice, SATC will provide victim advocates to the facility when needed.

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

Subsection (f): HYCF shall request that the investigating agency follow the requirements of this standard. The PREA Coordinator is responsible for quality assurance and adherence to this standard for conducting an administrative investigation and/or referral to law enforcement agency for investigating allegations of sexual abuse.

Subsection (g): The PREA Coordinator is responsible for quality assurance and adherence to this standard for conducting an administrative investigation and/or referral to law enforcement agency for investigating allegations of sexual abuse.

Subsection (h): The PREA Coordinator is responsible for quality assurance and adherence to this standard for conducting an administrative investigation and/or referral to law enforcement agency for investigating allegations of sexual abuse.

Interviews with random staff indicated they were not knowledgeable of the facility's protocols and procedures to immediately separate the victim and perpetrator; keep the youth safe; notify their supervisor; write out an incident report using a HYCF Form 200 Incident Report form, and secure the area for useable physical evidence. Staff reported that they would use protocols related to other incidents, such as use of force or suicides, and their "gut" instincts. The YFA, DYFA/PREA Coordinator and PREA Compliance Manager stated they would notify the appropriate supervisor, make appropriate referrals to medical and mental health; and, if needed, residents will be transported to SATC at Kapi'olani Medical Center for Women & Children Emergency Room for forensic medical examination by qualified SANE/SAFE medical staff. During the pre-audit HYCF submitted to the Auditor a *draft* PREA Incident Response Checklist form to ensure that all proper notifications and referrals in addition to key information about the incident to be implemented in the future.

**Corrective Action:**

1. HYCF must implement and train staff on the proper protocol for obtaining useable physical evidence for administrative proceedings and criminal prosecutions. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.
2. HYCF staff must be specifically trained on the portions of this Standard that address dealing with medical and mental health, victims and victim centric care. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.
3. HYCF must implement and train staff on the use of the PREA Incident Response Checklist form. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.

**Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on November 21 and 27, 2018, and December 4, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

**Additional Documentation Reviewed:**

1. Comprehensive PREA training was conducted at the facility which included initial training of HYCF upper management staff, including the OYS Executive Director, and HYCF trainers by The Moss Group. The Moss Group specifically tailored the curriculum and training based on HYCF facility's protocol for obtaining useable physical evidence for administrative proceedings and criminal prosecutions.
2. Staff training sign-in sheets showing all staff, received this training on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which included training on utilization of the PREA Incident Response Checklist form.
3. The Auditor conducted telephonic interviews with 15 random staff on December 5 and 10, 2018.

The Auditor confirmed that all HYCF staff received training for obtaining useable physical evidence for administrative proceedings and criminal prosecutions as set forth in their policy and this standard. HYCF administration implemented the PREA Incident Response Checklist form and all staff have received training the use of this form. During telephonic interviews with random staff, all staff were able to articulate their duties as enumerated in subsections of this Standard. This standard is now fully compliant and the facility meets this standard.

**Standard 115.322: Policies to ensure referrals of allegations for investigations**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.322 (a)**



- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?  Yes  No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?  Yes  No

#### 115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?  Yes  No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?  Yes  No
- Does the agency document all such referrals?  Yes  No

#### 115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]  Yes  No  NA

#### 115.322 (d)

- Auditor is not required to audit this provision.

#### 115.322 (e)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.10, *et seq.*
3. Draft PREA Incident Response Checklist form
4. HYCF Website: <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility>
5. Interviews with the following:
  - a. Agency Head
  - b. Investigative Staff

#### Findings (By Subsection):

Subsection (a): HYCF P&P policy requires that an administrative investigation is completed for all allegations of sexual abuse and sexual harassment, and a referral made for criminal investigations. The facility reported in the PAQ that in the past 12 months, four allegations of sexual abuse and sexual harassment were received resulting in completed administrative investigations; and none of the reported allegations were referred for criminal investigation. During the on-site audit the Auditor reviewed the four investigation files kept by the Investigator and confirmed all the investigations were completed in accordance with policy and procedures.

Subsection (b): HYCF staff shall complete the HYCF-200 Incident Report form and the HYCF PREA Incident Checklist for all allegations of sexual abuse and sexual harassment, contact the YFA and/or the agency Executive Director, and submit the completed forms to the PREA Coordinator. The Office of Youth Services (OYS), Executive Director stated the safety of the child and well-being of youth is very important, and everything that is reported is investigated and assigned to the Investigator. Interviews with the Executive Director and the Investigator confirmed that all allegations of sexual abuse or sexual harassment that involves potentially criminal behavior are immediately referred to the local law enforcement, which is the Honolulu Police Department. As of the date of the audit, the agency has not published any policy on its website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility> or made the policy available through other means as required by this subsection. During the pre-audit, the Auditor was told that the agency was working on putting together the PREA information to be published on its website, including information stating that all allegations of youth-on-youth sexual abuse and sexual misconduct are investigated. HYCF also submitted to the Auditor a draft PREA Incident Response Checklist form to ensure that all proper notifications and referrals in addition to key information about the incident to be implemented in the future.

Subsection (c): The HYCF policy states that the YFA shall make an official request for investigation of any allegation of sexual abuse or potentially serious incident of sexual harassment to the Executive Director. The administrative investigation is completed by an Investigator assigned by the OYS Executive Director. As of the date of the audit, the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/> does not provide any information describing who is responsible for conducting the administrative investigations and criminal investigations, including identifying who the local enforcement agency responsible for the criminal investigation; and the responsibilities of both the agency and the investigation agency during the investigation process. During the audit the Auditor was informed that the agency was working on putting together the PREA information to be published on its website that states that all allegations of youth-on-youth sexual abuse and sexual misconduct are criminally investigated by local law enforcement.

#### **Corrective Action:**

1. HYCF must develop and publish on its website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility> the information as required by this Standard as set out in subsection (b) and (c) above.

#### **Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 8 and 15, 2018, and November 30, 2018, to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

#### **Additional Documentation Reviewed:**

1. Documentation appearing on the agency's website at <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility> under the tab "Investigation of Sexual Abuse Allegations" publishes the policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to local enforcement with the legal authority to conduct criminal investigations, and the responsibilities of both the agency during administrative investigations and the investigation agency during criminal investigations.

OYS website at <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility> includes the information required by this standard. This standard is now fully compliant and the facility meets this standard.

## TRAINING AND EDUCATION

### Standard 115.331: Employee training

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?  Yes  No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?  Yes  No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?  Yes  No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?  Yes  No

### 115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?  
 Yes  No
- Is such training tailored to the gender of the residents at the employee's facility?  Yes  No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?  Yes  No

### 115.331 (c)

- Have all current employees who may have contact with residents received such training?  
 Yes  No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?  
 Yes  No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?  Yes  No

### 115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.11 *et seq.*
3. Training Records/Employee Personnel Files
4. Interviews with the following:
  - a. Random Staff
  - b. Random Residents

### Findings (By Subsection):

Subsection (a): HYCF submitted to the Auditor a sign-in roster for PREA 101 training conducted on November 29, 2016 for some of the staff and Basic Youth Correctional Training 15-02 on PREA conducted on June 25, 2015. HYCF has been without a training officer for over 12 months prior to the audit and the PREA Coordinator was unable to locate the PREA training module/curriculum that was used for these trainings for the Auditor's review verifying that the training

provided met the 11 subsections as listed in this standard. During the interim, no other staff member was to fill this vacancy. As part of the pre-audit information, the Auditor was informed that there has been no staff training on this Standard, and this was confirmed during interviews with staff.

Subsection (b): HYCF policy states that training is tailored to the unique needs and attributes of juveniles and to the gender of the residents in the facility; and all HYCF employees are trained universally to facilitate assignments supervising male or female residents. HYCF has been without a training officer for over 12 months prior to the audit, and no other staff member was assigned in the interim to fill this vacancy. At the time of the on-site audit, the Auditor was informed that HYCF had just hired a person for the vacant training officer position and this person would start working in the training officer's position in the next couple of months.

Subsection (c): HYCF policy states the facility provides annual refresher training on PREA to all staff who work directly with residents. The facility reported in the PAQ that zero (0) staff have currently been trained or received refresher training on the PREA requirements as enumerated in this standard and HYCF policy.

Subsection (d): HYCF policy states that the HYCF Training Unit is responsible for maintaining documentation to substantiate that employees have completed the required training, and a copy is provided to the PREA Coordinator within 3 working days of completion of the training. During the on-site audit, the Auditor was not able to review any staff training records as these records are unavailable or incomplete documenting that staff PREA training and annual PREA refresher training has occurred.

Interviews with all staff indicated they were not aware that the agency or facility had implemented HYCF PREA Policy 12.12, *et seq.*; they had not familiar with or had read HYCF PREA Policy 12.12 *et seq.*; and they had not any PREA training or refresher training on HYCF PREA Policy 12.12 *et seq.*. While staff were aware of their duty to protect the safety of the youth, staff indicated they were using training they had received for other protocols, e.g. suicide and use of force, for PREA incidents.

#### **Corrective Action:**

1. HYCF must ensure that *all* staff is trained on the PREA Standards and the curriculum covers the 11 elements set forth in this standard *as soon as possible*. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.
2. HYCF must ensure that all staff receives annual refresher training as set forth in their policy HYCF P&P 12.12.11(c). Documentation must be submitted to the Auditor to demonstrate this standard requirement.
3. As best practice, HYCF should consider implementation of ICF or policy stating that when the training officer's position is vacant for more than six months another staff person will be responsible for providing the annual PREA refresher training until a permanent training officer is hired. Documentation must be submitted to the Auditor regarding the agency's and facility's decision on this issue.

#### **Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on November 21 and 27, 2018, and December 4, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

#### **Additional Documentation Reviewed:**

1. Comprehensive PREA training was conducted at the facility which included initial training of HYCF upper management staff, including the OYS Executive Director, and HYCF trainers by The Moss Group. The Moss Group specifically tailored the PREA curriculum and training based on HYCF facility's protocol and procedures.

2. Staff training sign-in sheets showing all staff, received this training on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which included training on utilization of the PREA Incident Response Checklist form.
3. The Auditor conducted telephonic interviews with random staff on December 5 and 10, 2018.
4. Documentation was received on August 3, 2018, showing that the training officer position was filled with a permanent employee on May 1, 2018.
5. Review of the Training schedule for 2019 which shows PREA training scheduled for September and October.

HYCF administration conducted comprehensive PREA training for all staff, including HYCF upper management and OYS Executive Director, on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which addressed all the deficiencies in staff training raised by this audit, including training on special populations such as the LGBTI residents. With the hiring of a permanent training officer, HYCF administration has ensured that annual training will occur as required in their policy and this standard. The training officer has already scheduled refresher PREA training for 2019. The Auditor conducted telephonic interviews on December 5 and 10, 2018 with 15 random staff verifying their knowledge of the PREA standards and the quality of the PREA training they received. During telephonic interviews with random staff, all staff were able to articulate their duties as enumerated in subsection (a) of this Standard. This standard is now fully compliant and the facility meets this standard.

## Standard 115.332: Volunteer and contractor training

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?  Yes  No

#### 115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?  Yes  No

#### 115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")

2. HYCF P&P 12.12.4.12, *et seq.*
3. Interviews with the following:
  - a. Contractors
  - b. Volunteers

**Findings (By Subsection):**

Subsection (a): HYCF policy states that all volunteers and contractors who have contact with residents will be trained on their responsibilities under HYCF's PREA policy regarding the prevention, detection, response to sexual abuse and sexual harassment, and how to report it. This training is supposed to be done during orientation. The facility reported in the PAQ that zero (0) volunteers and contractors who have contact with residents have been trained or retrained in the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Interview with two contractors and two volunteers indicate that they were aware of the facility's zero-tolerance

Subsection (b): HYCF provides orientation training to volunteers and contractors based on the services they provide and the level of contact. The facility reported in the PAQ that not all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. During the pre-audit the Auditor was provided a copy of the draft Volunteer/ Contractor Notice of Zero Tolerance Policy form that will be provided to each volunteer and contractor, along with the a copy of HYCF's PREA policies, and requiring each contractor's/volunteer's signature certifying they have read and understand the facility's zero-tolerance policy for sexual abuse. This form has not been implemented as of the date of the on-site audit. Interview with random contractors and volunteers who have contact with residents indicate that they were aware of the facility's policy on zero-tolerance on sexual abuse and sexual harassment and stated who they to report such incidents to at the facility.

Subsection (c): Per policy, the HYCF Training Unit maintains documentation confirming that volunteers and contractors have received appropriate level of training and they understood the information provided, and a copy is provided to the PREA Coordinator within three working days of completion of the training. During the on-site audit, there were volunteer or contractor records documenting initial PREA training and annual refresher training for the Auditor to review.

**Corrective Action:**

1. HYCF should ensure that all volunteers and contractors who have contact with residents receives training on the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and reporting response. Documentation of training curriculum and training sign-in sheets for all contractors and volunteers must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.
2. HYCF should ensure that all volunteers and contractors receive annual PREA refresher training one year from the date they receive their initial PREA training. Documentation of training curriculum and training sign-in sheets for all contractors and volunteers must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.

**Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 3, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

**Additional Documentation Reviewed:**

1. Documentation showing all volunteers, contractors, and subcontractors have received PREA training and retraining on June 28, 2018
2. The Auditor conducted telephonic interviews with 4 random contractors on December 10, 2018.

HYCF administration conducted comprehensive training for all volunteers and contractors on June 28, 2018 to address any deficiencies in training raised by this audit. During telephonic interviews with 4 random contractors, all contractors were able to articulate their duties as enumerated in this Standard. This standard is now fully compliant and the facility meets this standard.

## Standard 115.333: Resident education

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- Is this information presented in an age-appropriate fashion?  Yes  No

#### 115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?  Yes  No

#### 115.333 (c)

- Have all residents received such education?  Yes  No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?  Yes  No

#### 115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?  Yes  No



- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?  Yes  No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?  Yes  No

### 115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions?  Yes  No

### 115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.13, *et seq.*
3. HYCF PREA Orientation Form
4. Script for PREA Orientation for Newly Committed Juveniles to HYCF
5. *End the Silence: Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)*
6. How to Avoid Risky Situations sheet
7. Department of Human Services Internal Communication Form (IFC), Subject: Zero Tolerance, dated October 9, 2015
8. Department of Human Services Internal Communication Form (IFC), Subject: Fraternalization, dated October 9, 2015
9. Video presentation on PREA shown at Intake
10. HYCF Youth Handbook
11. *End the Silence* Comic Books series
12. HYCF Consent to Treatment and Medication
13. HYCF PREA Intake Orientation checklist form
14. HYCF Housing Assessment Form
15. Parent Handbook, March 2015
16. On-site Tour of facility
17. Review of resident files
18. Interviews with the following:
  - a. Intake Staff – Social Workers
  - b. Random Residents

### Findings (By Subsection):

Subsection (a): HYCF policy requires that during the intake process all residents receive information in an age appropriate fashion; HYCF's zero tolerance policy regarding sexual abuse and sexual harassment; and how to report incidents or suspicions of sexual abuse or sexual harassment.

Intake orientation is conducted by the resident's Social Worker usually within hours of arrival unless the resident arrives after the close of the business day. On such occasions, intake occurs the following day, unless the resident arrives late on a Friday or over the weekend when intake occurs Monday morning. Per interview with the Social Workers, the Auditor was informed by the Social Workers that the first information they review with each new resident during orientation is the PREA Orientation Form and the script for PREA Orientation for Newly Committed Juveniles to HYCF, and reviews the following information with the resident: (1) *End the Silence: Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)*; (2) how to avoid risky situations; (3) IFC Form on Zero Tolerance and Fraternalization; (4) shows the resident the PREA video presentation; (5) reviews the HYCF Youth Handbook with PREA Orientation supplemental information such as the *End the Silence* Comic Books series; (6) reviews and administers HYCF PREA Intake Orientation checklist form where both the resident and Social Worker initial each of the 15 items on the checklist dealing with sexual abuse and sexual harassment; and (7) administers the HYCF Housing Assessment form. This information was also confirmed by the Auditor during interviews with random residents and review of five resident files.

Subsection (b): HYCF policy requires residents be provided with comprehensive age-appropriate education within 10 days of intake either in person or through video. Both the resident and the social worker initial and date each of the documents during orientation. This information was confirmed during the Auditor's review of five resident files.

Subsection (c): The facility reported in the PAQ that all residents have received PREA training. This information was confirmed by the Auditor during the interview with the Social Workers and a random review of five resident files.

Subsection (d): HYCF policy requires the facility to ensure the resident education is accessible in formats as needed for LEP, deaf, visually impaired, or otherwise disabled residents. Accommodations are made through the agency's services, and a list of authorized interpreters is available through the Department of Human Services Civil Rights Office. For residents who are visually impaired, the Social Workers stated they would read the above-mentioned information to the resident one-on-one and ensures the understanding. The Social Workers also document whenever specialized services are offered, refused and/or provided to residents on the appropriate form and a copy is forwarded to the PREA Coordinator via the PREA box located at Central Control within three days.

Subsection (e): The resident and Social Worker both signs and initials the PREA Orientation Form and PREA Intake Orientation form and copies are placed in the resident's institutional file. This original documentation is forwarded to the PREA Coordinator via the PREA box located at Central Control within three days. This information was confirmed during interview with the Social Workers and the Auditor's review of five resident files.

Subsection (f): HYCF ensures that educational materials are continuously and readily available and visible to residents about PREA through posters, the resident handbook, and other resources in other written formats. The Auditor observed during the tour of the facility that all housing cottages, school programming areas, library, gymnasium, attorney and parent visitation areas, and kitchen work areas have PREA informational posters.

As part of the PAQ documentation, the Auditor was provided a copy of the monthly HYCF Physical Plant Vulnerability Assessment for the past 12 months, and noted that the CS1 staff were providing a negative response to Question #6 regarding Zero Tolerance Posters being displayed throughout the facility. According to the PREA Coordinator, this was response was due to the fact that there was no PREA poster in the gymnasium. The Auditor observed a PREA poster during the on-site tour of the facility and was told that a bigger poster had been ordered.

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

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

**Corrective Action:** None.

## Standard 115.334: Specialized training: Investigations

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  
 Yes  No  NA

#### 115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.334 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.14, *et seq.*
3. Personnel records for Investigative Staff showing training records
4. Certificate of Completion of the three-day Sexual Assault Investigation Training held on February 22-24, 2017 by the Massachusetts Department of Correction under the PREA Grant Project
5. Certificate of Training of completion of 24.5 hours of training in Multi-disciplinary Team Response to Child Sex Trafficking held on September 11-14, 2017 from the National Criminal Justice Training Center
6. Certificate of Training of completion of State of Hawaii Investigator Course held on April 26-27, 2016
7. Interview with the following:
  - a. Investigative Staff

**Findings (By Subsection):**

Subsection (a): HYCF conducts administrative investigations for allegations of sexual abuse and sexual harassment. The Investigator provided a copy of the curriculum and the Certificate of Completion for the three-day Sexual Assault Investigation Training held on February 22-24, 2017 by the Massachusetts Department of Correction under the PREA Grant Project.

Subsection (b): The specialized investigator training provided by PREA Grant Project during the ACA meeting in Boston, MA in February 2017 that covered all the required components in this standard, including the use of *Garrity* warnings and *Miranda* warnings for compelled staff interviews.

Subsection (c): HYCF maintains documentation substantiating that OYS investigators have completed the required specialized training in the staff member’s training record with HYCF and DHS, and with the PREA Coordinator.

Subsection (d): HYCF policy allows for the OYS/HYCF investigator to comply with this provision through webinars for Specialized PREA Investigations Training officer at the PRC website and the National Institute of Corrections website and/or through other means that become available.

During the on-site audit, the Auditor interviewed the Investigator who demonstrated a thorough working knowledge of PREA and how to appropriately conduct investigations concerning allegations of sexual abuse or sexual harassment.

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

**Corrective Action:** None.

## **Standard 115.335: Specialized training: Medical and mental health care**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.335 (a)**

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?  Yes  No

#### 115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.)  Yes  No  NA

#### 115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?  Yes  No

#### 115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.15, *et seq.*
3. Certificate of Completion of PREA: Your Role Responding to Sexual Abuse Presented by National Institute of Corrections
4. Certificate of Completion of Communicating Effectively and Professionally with LGBTI Offenders Presented by National Institute of Corrections

5. Certificate of Completion of PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting presented by National Institute of Corrections
6. Certificate of Completion of Respectful Communication with LGBTQI Youth presented by National Institute of Corrections
7. Certificate of Completion of PREA: Audit Process and Instrument Overview presented by National Institute of Corrections
8. Certificate of Completion of PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting presented by National Institute of Corrections
9. Interviews with the following:
  - a. Medical Staff
  - b. Mental Health Staff

**Findings (By Subsection):**

Subsection (a): HYCF policy requires all full-time and part-time and contract medical and mental health care practitioners who work regularly at HCYF to be trained in the standards as set forth in this standard. The facility reported in the PAQ there are 12 medical and mental health care practitioners who work regularly at HYCF, and that they have received the training required by the agency’s policy. During the on-site audit, the Auditor confirmed with the medical and mental health staff that they have received the PREA training for employees and contractors.

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

Subsection (c): HYCF has documentation on the on-line training provided by National Institute of Corrections. During the on-site audit, the Auditor verified that all medical and mental health care practitioners have received the specialized medical training as required by HYCF policy and the Standard.

Subsection (d): HYCF policy requires that medical and mental health care practitioners receive the same training for employees and contractors under 12.12.4.11 (employees) and 12.12.4.12 (contractors and volunteers). During the on-site audit, the Auditor verified that all medical and mental health care practitioners have received the training as required by HYCF policy and the standard.

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

**Corrective Action:** None.

**SCREENING FOR RISK OF SEXUAL VICTIMIZATION  
AND ABUSIVENESS**

**Standard 115.341: Screening for risk of victimization and abusiveness**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.341 (a)**

- Within 72 hours of the resident’s arrival at the facility, does the agency obtain and use information about each resident’s personal history and behavior to reduce risk of sexual abuse by or upon a resident?  Yes  No

- Does the agency also obtain this information periodically throughout a resident's confinement?  
 Yes  No

#### 115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument?  
 Yes  No

#### 115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?  Yes  No

#### 115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?  Yes  No

- Is this information ascertained: During classification assessments?  Yes  No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?  Yes  No

### 115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.16, *et seq.*
3. Screening Form Youth Assessment and Screening Instrument ("YASI")
4. HYCF Housing Assessment Form
5. Random Resident Files
6. Interviews with the following:
  - a. PREA Coordinator
  - b. PREA Compliance Manager
  - c. Risk Screening Staff – Social Workers
  - d. Random Residents

### Findings (By Subsection):

Subsection (a): HYCF policy requires screening within 72 hours of the resident's arrival. At HYCF the Social Worker is responsible for conducting risk screening at the facility. Interviews with the Social Workers indicate that the risk screening is typically done within the hours of the resident's arrival or within 48 hours of arrival should the resident arrive during the evenings or over the weekend. HYCF policy also requires periodical review of each resident's institutional record throughout the resident's confinement, consistent with the monthly continuing case plan review, or when a referral, request, incident of sexual abuse, or receipt of additional information that may impact the risk level of sexual abuse by or upon a resident. Interviews with the Social Workers confirmed that each resident's file is reviewed monthly during Multidisciplinary Team ("MDT") meeting and calendared for a review every three months. The facility reported in the PAQ that 34 residents entered the facility in the past 12 months whose length of stay in the facility was for 72 hours or more were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into HYCF. A review of random resident files confirmed that the resident was screened within 48 hours of arrival utilizing the information from YASI and the HYCF Housing Assessment Form; and each resident receives a monthly review during MDT meeting or following an incident involving the resident.



Subsection (b): HYCF uses an objective screening instrument known as YASI, an objective behavioral screening instrument.

Subsection (c): The HYCF utilizes the YASI screening instrument to ascertain information about all 11 enumerated items in this standard to determine proper housing, bed assignment, education, and other programs assignments with the goal of keeping residents at high risk of being sexually abused and sexually harassed separate from residents who are at high risk of being sexually abusive. The Auditor was informed that the resident's Probation Officer will complete the YASI screening form prior to the resident's arrival at HYCF and the Social Worker will also review the information with the resident.

Subsection (d): HYCF policy ensures that the information be ascertained through conversation with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Residents are not forced or disciplined for refusing to answer or for not disclosing complete information. Interviews with the Social Workers indicate they are reviewing all of the information as outlined in this subsection during risk screening.

Subsection (e): HYCF controls the dissemination of the information obtained in the screening instrument, and staff receive training on confidentiality and victim advocacy.

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

**Corrective Action:** None.

## Standard 115.342: Use of screening information

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?  
 Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?  
 Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?  
 Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?  
 Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?  
 Yes  No

**115.342 (b)**

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?  Yes  No
- Do residents in isolation receive daily visits from a medical or mental health care clinician?  
 Yes  No
- Do residents also have access to other programs and work opportunities to the extent possible?  
 Yes  No

**115.342 (c)**

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  
 Yes  No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?  Yes  No

**115.342 (d)**

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?  Yes  No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?  Yes  No

**115.342 (e)**

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?  Yes  No

**115.342 (f)**

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?  Yes  No

#### 115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents?  Yes  No

#### 115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)  Yes  No  NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)  Yes  No  NA

#### 115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.17, *et seq.*
3. Review of YASI Screening Form
4. HYCF Housing Assessment Form
5. Random Resident Files
6. Interviews with the following:
  - a. PREA Coordinator
  - b. PREA Compliance Manager
  - c. Risk Screening Staff – Social Workers
  - d. Staff Who Supervise Residents in Isolation
  - e. Random Residents

#### Findings (By Subsection):

Subsection (a): HYCF policy requires the information obtained in the screening and intake process be used to make housing and other assignments with the goal of keeping residents safe and free from sexual abuse. Interviews with specialized staff indicate the information is being used to make decisions on resident housing and programming.

Subsection (b): While the facility uses isolation, HYCF policy states that resident may be isolated from others as a last resort when less restrictive measures are inadequate to keep them and other residents safe. Isolation shall be in accordance with the Administrative Respite and Transition (ART) Program, and the length of stay in the ART Program is only until an alternative means if keeping all residents safe can be arranged. Residents in the ART Program or other form of isolation shall not be denied daily large-muscle exercise, legally required educational programming, special education services or religious rights; and shall also have access to other programs and work opportunities to the extent possible while maintaining a safe environment for all residents. Medical or mental health care staff shall visit and assess the resident daily. The facility reported in the PAQ that in the past 12 months no resident at risk of sexual victimization was placed in isolation or held in isolation to protect them from sexual victimization. This was confirmed by the Auditor during interviews YFA, PREA Coordinator, medical staff, and mental health staff.

Subsection (c): HYCF policy ensures lesbian, gay, bisexual, transgender or intersex resident are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status; nor shall their identification or status be used as an indicator of likelihood of being sexually abusive.

Subsection (d): HYCF policy ensures that housing and programming assignments for lesbian, gay, bisexual, transgender or intersex residents is on a case-by-case basis to ensure the resident's health and safety, while considering facility management and/or security concerns. Interviews with staff corroborate that the placement of LGBTQI residents is made on a case-by-case basis.

Subsection (e): HYCF policy ensures resident placement and programming assignments is reassessed monthly or at least twice each year to review any threats to safety experienced by the resident for each transgender or intersex resident. The Treatment Team discussed and documents the review and any status and changes on the resident's Continuous Case Plan (CCP) or equivalent document. Interviews with staff corroborate that the MDT reviews LGBTQI residents monthly.

Subsection (f): HYCF policy requires staff to respect the opinion and views of a transgender or intersex residents in regard to his or own safety and shall give serious consideration to their requests while ensuring their health and safety and the good management and orderly running of the facility. Interviews with all specialized staff indicate that the views of an LGBTQI resident are given serious consideration and they normally accommodate the resident's request for housing assignment.

Subsection (g): HYCF policy ensures that transgender and intersex residents are provided the opportunity to shower separately from other residents in dorm shower situations when requested. All residents at HYCF shower separately from each other.

Subsection (h): HYCF policy requires that whenever a resident is segregated staff shall clearly document the basis for the concern for the resident's safety and the reason why no alternative means of separation can be arranged. The facility reported in the PAQ in the past 12 months they have had no resident at risk of sexual victimization placed in isolation.

Subsection (i): HYCF policy requires a review at least every 30 days for each resident being held in segregation to determine whether there is a continuing need for separation from the general population. This review shall be conducted at the scheduled monthly MDT meeting and is documented on the CCP or other appropriate document with a copy provided to the resident.

During the on-site audit, the Auditor reviewed 5 random completed resident screening forms to verify that the facility uses information from the risk screening and Housing Assessment form to inform housing, bed, education, and program assignments. At the time of the audit, there were no residents being housed who identified themselves as LBGTQI.

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

**Corrective Action:** None.

## REPORTING

### Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?  Yes  No

#### 115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?  Yes  No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?  Yes  No
- Does that private entity or office allow the resident to remain anonymous upon request?  Yes  No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?  Yes  No

#### 115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?  Yes  No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?  Yes  No

## 115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report?  
 Yes  No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.18, *et seq.*
3. HYCF P&P 12.10 Youth Grievance
4. HYCF Youth Handbook
5. HYCF Parent Handbook, dated March 2015
6. *End the Silence: Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)*
7. Grievance Form (HYCF Form-225)
8. On-site review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
9. Interviews with the following:
  - a. PREA Coordinator
  - b. PREA Compliance Manager
  - c. Random Residents
  - d. Random Staff

### Findings (By Subsection):

Subsection (a): HYCF policy provides multiple internal ways for residents to privately report PREA related incidents. These include making verbal or written reports on any form of writing material to any HYCF staff, education employees, FCLB employee, contract employee or volunteer. Resident may also submit confidential written requests to the PREA Coordinator by placing it in the box designated as PREA fronting the Central Control in Secured Correctional Facility (SCF) or in a sealed envelope addressed to PREA and placed in the grievance boxes located throughout the facility. Residents may also utilize the grievance procedure.

Subsection (b): HYCF provides information and education to residents on how to report sexual abuse, sexual harassment, and retaliation to a public entity, private entity, or an external agency that are able to receive and immediately forward residents reports of sexual abuse and sexual harassment to agency officials, allowing offenders to remain anonymous upon request. HYCF provides the address and phone numbers for residents, staff and others may report incidents of sexual abuse, sexual harassment and retaliation to the Ombudsman, legislative or political representatives, Department of Attorney General, OYS Executive Director, YFA, Deputy YFA, and the Sexual Abuse Hotline. Policy also provides that should a resident be detained at HYCF solely for civil immigration purpose they shall

be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

During the on-site audit, the Auditor observed PREA posters with toll-free numbers in every area of the. Telephones are available in all three cottages and the resident must ask the Youth Correctional Officer (YCO) to use the phone. Interviews with residents indicated knowledge procedures for reporting, including the use of the toll-free telephone number, and would report any incident to a staff member they trust or to their family member.

Subsection (c): HYCF policy mandates that all staff accept reports of sexual assault and sexual harassment made verbally, in writing anonymously, and from third parties. All staff shall immediately document all verbal reports and notify superiors through the chain of command by utilizing the HYCF-200 Incident Reporting form. Staff will also complete HYCF PREA Incident Checklist and forwarded to the PREA Coordinator either directly or via the PREA box located at Central Control by the end of the shift. Interviews with staff indicate they would accept verbal and written reports, they would immediately report this to the chain of command telling their YCS or CS1, and they would document their report on HYCF-200 or ICF.

Subsection (d): HYCF policy ensures that staff shall provide residents with access to tools necessary to make a written report and provide assistance if requested, including transcribing the resident's verbal report. Residents with LEP or disabilities shall be afforded appropriate services, free of cost, to assist in transcribing his/her report. Interviews with staff indicated they would assist any resident who was unable to write their own report.

Subsection (e): HYCF policy allows for staff to privately and anonymously report sexual abuse and sexual harassment of resident to the Ombudsman, Sex Abuse Hotline, upper management Administrator or Deputy Administrator, directly to the PREA Coordinator. Interviews with staff indicated knowledge procedures for reporting, including the use of the toll-free telephone number.

Through telephone conversation with the Supervisor in the Hawaii Ombudsman's office, the Auditor confirmed they have agreed to receive sexual abuse reports from HYCF residents and staff, and will immediately forward resident reports to the proper agency when they receive it. The Auditor also confirmed the telephone number with the Sexual Abuse Hotline was an active telephone number and that they receive reports from HYCF residents and staff.

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

**Corrective Action:** None.

## **Standard 115.352: Exhaustion of administrative remedies**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.352 (a)**

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.  Yes  No  NA

#### **115.352 (b)**

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)  Yes  No  NA



- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)  Yes  No  NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)  Yes  No  NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.19, *et seq.*

3. HYCF P&P 12.10 Youth Grievance
4. HYCF Youth Handbook
5. HYCF Parent Handbook, dated March 2015
6. *End the Silence: Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)*
7. Grievance Form – HYCF Form-225
8. On-site review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
9. On-site random review of all Grievances submitted during 2017
10. Interviews with the following:
  - a. PREA Coordinator
  - b. PREA Compliance Manager
  - c. Random Residents
  - d. Random Staff

### **Findings (By Subsection):**

Subsection (a): HYCF has a grievance policy set forth in HYCF P&P 12.10, and is not exempt from this standard. HYCF P&P 12.12.4.19 grievance process outlines the administrative procedure available to residents and family for reporting incidents of sexual abuse, sexual harassment, or retaliation. Grievance forms are available from the Grievance Officer, any staff member, and in the school, maintenance, medical, and kitchen areas. The facility reported in the PAQ they had received four grievances alleging sexual abuse that reached the final decision within 30 days. Currently HYCF does not have a Grievance Officer and the Investigator does the initial review and response. During the on-site audit the Auditor reviewed the four grievances alleging sexual abuse, and conducted a random search of all grievances filed in 2016 and 2017.

Subsection (b): HYCF P&P 12.12.4.19 prohibits any time limit from being imposed on any grievance when a resident submits a grievance regarding an allegation of sexual abuse. Staff shall not require a resident to use any informal grievance process or to otherwise attempt to resolve with staff an alleged incident of sexual abuse. Grievance Form HYCF-225 has no time limit for filing any grievance for any subject matter.

Subsection (c): HYCF P&P 12.12.4.19 makes provisions for the resident to submit a grievance without submitting it to the staff members who is the subject of the complaint. At no time shall the grievance be referred to the staff member who is the subject of the grievance complaint. Residents are also permitted to submit a grievance anonymously by placing the grievance in a secured grievance box at various locations throughout the facility. The Grievance Officer/staff member assigned to retrieve grievance from the grievance boxes shall ensure that a grievance regarding an allegation of sexual abuse is forwarded directly to the YFA or designee for proper action.

Subsection (d): HYCF P&P 12.12.4.19 ensures that a final decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the initial filing of the grievance.

Subsection (e): HYCF P&P 12.12.4.19(k), (l), (m), and (n) addresses the requirements of this standard regarding the ability of third parties to file grievances with and/or on behalf of residents. Address and contact information is also provided on page 15 of The Parents Handbook. The policy ensures that HYCF will document if a resident declines to have the request processed on his or her behalf on the HYCF Third Party Waiver form, which is forwarded to the PREA Coordinator within three days. During the pre-audit review, the Auditor was informed that HYCF will conduct a preliminary review the incident on a case-by-case basis to see if the reported incidents merits further investigation.

Subsection (f): HYCF P&P 12.12.4.19 ensures that residents may file an Emergency Youth Grievance Complaint whenever the resident is subject to a substantial risk of imminent sexual abuse. Staff shall immediately forward the grievance to the YFA or designee where immediate corrective action may be taken. The YFA shall provide an initial response within 48 hours of receipt of the grievance or verbal notification, and shall issue a final decision within 5 calendar days. The

initial response and final decision shall documents HYCF's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The facility reported in the PAQ they had received no emergency grievances alleging substantial risk of imminent sexual abuse in the past 12 months.

Subsection (g): HYCF P&P 12.12.4.19 allows HYCF to discipline a resident for filing a grievance related to alleged sexual abuse or sexual harassment when HCYF demonstrates that the resident filed the grievance in bad faith. The facility reported in the PAQ that they had received no grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith in the past 12 months.

The Auditor was able to determine through interviews with staff and residents that residents are aware of the grievance process and being able to utilize the grievance process to report sexual abuse and sexual harassment.

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

**Corrective Action:** None.

## **Standard 115.353: Resident access to outside confidential support services and legal representation**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.353 (a)**

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?  Yes  No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

#### **115.353 (b)**

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?  Yes  No

#### **115.353 (c)**

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?  Yes  No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?  Yes  No

## 115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?  Yes  No
- Does the facility provide residents with reasonable access to parents or legal guardians?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.20, *et seq.* and HYCF P&P HYCF 12.12.4.22(e)
3. HYCF Youth Handbook
4. HYCF Parent Handbook, dated March 2015
5. Memorandum of Understanding (MOU) with Sex Abuse Treatment Center (SATC) of the Kapi'olani Medical Center for Women & Children, dated September 19, 2016
6. HYCF Form Consent to Treatment and Medication Terms and Conditions of Services.
7. On-site Audit review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
8. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Random Staff
  - e. Random Residents
  - f. Advocacy Services

### Findings (By Subsection):

Subsection (a): HYCF has a MOU with SATC who provides residents with access to outside victim advocates for emotional support services related to sexual abuse. During the telephone conversation with the Associate Director of SATC, the Auditor was informed that SATC will provide victim advocacy services for the resident, that there is always a victim crisis counselor during the exam, and they will provide follow-up services for both short-term and long-term therapy. Pursuant to policy, the facility also provides addresses and toll free hotline telephone numbers to the following outside victim advocates and enables reasonable communication in as confidential a manner as possible with the following: the Hawaii Sexual Abuse Hotline, the Hawaii State Coalition Against Domestic Violence, the Hawaii Coalition Against Sexual Assault, and Prevent Child Abuse Hawaii. Residents are provided information on page 8 of the Youth Handbook Information with toll-free hotline telephone numbers for the 24-hour Sex Abuse Hotline and the Child Protection Services Hotline. Parents are provided contact and information in the Parents Handbook on pages 15-16. The facility provides this information to any resident who is detained solely for immigration purposes. During the on-site audit the

Auditor observed posters displaying the contact information throughout the facility, including all housing wings, dining room, kitchen, library, all classrooms, gym, medical and mental health areas, and hallways, providing residents with the address and toll-free number for outside victim services. The Auditor was able to determine through interviews with random staff and residents that residents are aware of how to access outside confidential support services in cases of sexual abuse and where the telephone numbers are located.

Subsection (b): HYCF policy ensures that staff and medical/mental health staff inform residents, prior to giving them access to outside support services, of the extent to which such communication will be monitored, including the mandatory reporting requirements and the limits to confidentiality. HYCF policy 12.12.4.22(e) requires medical and mental health care practitioners to inform residents at the initiation of services of their duty to report and the limitations of confidentiality through the use of the HYCF Form Consent to Treatment and Medication Terms and Conditions of Services. Residents are advised of this limit to confidentiality on page 8 of the Youth Handbook Information and by medical/mental health staff.

Subsection (c): The agency maintains a copy of the Memorandum of Understanding (MOU) with Sex Abuse Treatment Center (SATC) of the Kapi'olani Medical Center for Women & Children, dated September 19, 2016.

Subsection (d): HYCF policy provides residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Parents are provided this information in the Parents Handbook on page 4. Residents confirmed they can meet with their parents and attorneys in a private area.

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

**Corrective Action:** None.

## Standard 115.354: Third-party reporting

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?  Yes  No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")

2. HYCF P&P 12.12.4.21, *et seq.*
3. HYCF Youth Handbook
4. HYCF Parent Handbook, dated March 2015
5. Agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility>
6. On-site Audit review of housing areas, gymnasium, program areas, kitchen area, education area, and medical areas specifically reviewing PREA information visible and grievance box locations
7. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator
  - c. PREA Compliance Manager

**Findings (By Subsection):**

Subsection (a): HYCF policy ensures that agency and facility staff may receive sexual abuse and sexual harassment reports from third-party sources from resident's family members or the public and that any third-party report will be forwarded to the YFA. The agency and facility publically distributes information on how to make third-party reports on page 15-16 in the Parent Handbook and on the agency's website at <http://humanservices.hawaii.gov> and <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility>. The policy lists the following addresses and telephone numbers for the following agencies where third-party reports may directly be submitted anonymously: Office of Youth Services Executive Director; the YFA, Hawaii Attorney General's Office; OYS/HYCF Investigator; Deputy YFA; Office of the Ombudsman; Honolulu Police Department; Hawaii Sex Abuse Hotline; Hawaii State Coalition Against Domestic Violence; Hawaii Coalition Against Sexual Assault; Sexual Abuse Treatment Center at Kapi'olani Medical Center for Women & Children; and Prevent Child Abuse Hawaii.

The Auditor was able to determine through interviews with random residents and staff that both residents and staff are of the procedures for third-party reporting.

**Corrective Action:** None.

**OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT**

**Standard 115.361: Staff and agency reporting duties**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.361 (a)**

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?  Yes  No

### 115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?  
 Yes  No

### 115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?  Yes  No

### 115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?  Yes  No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?  Yes  No

### 115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?  Yes  No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?  Yes  No
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)  
 Yes  No  NA
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?  Yes  No

### 115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.22, *et seq.*
3. Hawaii Revised Statutes § 350
4. HYCF P&P 1.15, *et seq.*, Subject: *Administrative Investigations*
5. DHS Guide for Mandated Reporters – Child Welfare Services, dated April 2015
6. DHS 1516 Form – Mandated Reporter Checklist for Suspected Child Abuse and Neglect
7. HYCF Consent to Treatment and Medication Terms and Conditions of Services Form
8. HYCF 200 Incident Report Form
9. Interviews with the following:
  - a. Facility Head
  - b. Medical and Mental Health Staff
  - c. Investigator
  - d. Random Staff
  - e. Random Residents

**Findings (By Subsection):**

Subsection (a): HYCF policy requires all staff to immediately report as directed by agency policy and Hawaii Revised Statutes § 350 any knowledge, suspicion, or information they receive regarding (1) any incident of sexual abuse or sexual harassment that occurred in the facility, on the facility grounds, or any other area that is not part of HYCF; any retaliation against a resident or staff who reported such an incident; and (3) any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. DHS has provided *A Guide for Mandated Reporters* outlining the steps staff are required to complete, including the completion of DHS 1516 Form Mandated Reporter Checklist for Suspected Child Abuse and Neglect, immediately calling the Child Welfare Services Intake Unit on the toll-free number to report their findings, and then fax a copy of their report.

Subsection (b): As set forth in Hawaii Revised Statutes § 350, HYCF staff are required to complete DHS 1516 Form Mandated Reporter Checklist for Suspected Child Abuse and Neglect, and immediately call the Child Welfare Services Intake Unit on the toll-free number to report their findings and then fax a copy of their report.

Subsection (c): HYCF policy prohibits staff from revealing any information related to sexual abuse report to anyone other than and to the extent necessary to manage, make treatment, investigate, or other security decisions, inclusive of reporting to designated supervisors or officials and designated state or local service agencies.

Subsection (d): HYCF policy requires medical and mental health care practitioners to inform residents at the initiation of services of their duty to report and the limitations of confidentiality through the use of the HYCF Form Consent to Treatment and Medication Terms and Conditions of Services.

Subsection (e): HYCF policy specifically addresses the requirements of this subsection the Standard requiring the YFA or his/her designee to promptly report the allegations. The YFA stated that he will report all allegations of sexual abuse and sexual harassment to the OYS Executive Director, and the Executive Director will assign it to the Investigator.

Subsection (f): HYCF policy 12.12.4.22(i) requires all staff to report all allegations, including third-party and anonymous reports, of sexual abuse and sexual harassment on HYCF Form 200 Incident Report form through the chain of command, and a copy forwarded to the PREA Coordinator within three days. The YFA or his designee will refer any and all investigations. HYCF P&P 1.15.3 states that OYS shall initiate administrative investigations of all allegations of complaints, serious incidents, and expedited grievances, and the investigations shall be documented and completed in a



timely manner. HYCF P&P 1.15.4 states the OYS Executive Director shall initiate the investigations and assign the investigation to the OYS Administrative Investigator who will conduct the investigation. The YFA stated that he will report all allegations of sexual abuse and sexual harassment to the OYS Executive Director, and the Executive Director will assign it to the Investigator.

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

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

Corrective Action: None.

## Standard 115.362: Agency protection duties

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.23, *et seq.*
3. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator
  - c. Random Staff

#### Findings (By Subsection):

Subsection (a): HYCF policy requires staff to take immediate action to protect the resident when staff learns that any resident is subject to a substantial risk of imminent sexual abuse without unreasonable delay until such time the YFA or the Treatment Team process can determine a long term resolution. As of the date of the audit, the facility reported in the PAQ that within the past 12 months they have not received or made any determination that a resident was subject to a substantial risk of imminent sexual abuse.

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

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

**Corrective Action:** None.

## Standard 115.363: Reporting to other confinement facilities

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?  Yes  No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency?  Yes  No

#### 115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?  Yes  No

#### 115.363 (c)

- Does the agency document that it has provided such notification?  Yes  No

#### 115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.24, *et seq.*
3. Interviews with the following:
  - a. Agency Head

- b. Facility Head
- c. PREA Coordinator

**Findings (By Subsection):**

Subsection (a): HYCF policy requires that upon receipt of a report that a resident was sexually abused while confined at another facility to notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. As of the date of the audit, the facility reported that in the past 12 months they have not received any allegation that a resident was abused while confined at another facility.

Subsection (b): HYCF policy requires the YFA to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. Interview with the YFA confirmed that he would make all notifications.

Subsection (c): HYCF policy requires documentation by submitting an Inter-Office Communication Form or correspondence on facility letterhead with the Agency contacted, name and title of person contacted, date and time contacted, method of contact, name of the resident or residents involved and a brief description of the allegation, with a copy of this documentation forwarded to the PREA Coordinator via email, fax or placed in the PREA box within three days of notification.

Subsection (d): HYCF policy requires the YFA or agency office that receives such notification shall require and advise the other facility that the allegation must be investigated in accordance with the PREA standards. As of the date of the audit, the facility reported within the past 12 months they have not received any allegation that a resident was abused from other facilities.

During the interview with the OYS Executive Director and YFA they stated that all allegations of sexual abuse and sexual harassment received from another facility will be investigated. Per the YFA, the Deputy YFA will research the incident and ask for the incident to be investigated if the facility had not been previously aware of the incident. The YFA will report back to the agency that had filed the report stating they were aware of the incident and had previously investigated it or they were not aware of the incident and it was currently under investigation.

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

**Corrective Action:** None.

## Standard 115.364: Staff first responder duties

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes,

urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No

### 115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.25, *et seq.*
3. Interviews with the following:
  - a. Facility Head
  - b. Random Staff
  - c. Non-security Staff

### Findings (By Subsection):

Subsection (a): HYCF policy details staff and first responder duties in accordance with this subsection of this Standard. The facility reported in the PAQ that within the past 12 months they have received no allegations that a resident was sexually abused.

Subsection (b): HYCF policy ensures that if the first responder is not a security staff member, the staff responder shall separate the victim and the abuser, if feasible, request that the alleged victim not take any actions that could destroy physical evidence, and then immediately notify security staff.

Through interviews with a random staff and non-security staff it was determined that staff are knowledgeable regarding their first responder duties upon first learning of any allegation of sexual abuse or sexual harassment; however, this is due to their training in other situation such as a use of force incident and suicide, and not due any awareness of HYCF’s policy. All staff stated they would immediately separate the residents and contact their YCS and CS1; however, many staff were unsure of their duties after they contact their supervisor as set forth in this Standard.

### Corrective Action:

1. HYCF must develop and finalize a written institutional plan to reflect a comprehensive and inclusive first responder protocol. The finalized plan and any documents that are incorporated into or with the plan must be resubmitted to the Auditor. All staff must be trained on this protocol to ensure true comprehension and working knowledge of the protocol. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.

#### Verification of Corrective Action since the Audit:

The Auditor was provided supplemental documentation on November 21 and 27, 2018, and December 4, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

#### Additional Documentation Reviewed:

1. Comprehensive PREA training was conducted at the facility which included initial training of HYCF upper management staff, including the OYS Executive Director, and HYCF trainers by The Moss Group. The Moss Group specifically tailored the PREA curriculum and training based on HYCF facility's protocol and procedures, including first responder duties.
2. Staff training sign-in sheets showing all staff, received this training on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which included training on utilization of the PREA Incident Response Checklist form and first responder duties.
3. The Auditor conducted telephonic interviews with random staff on December 5 and 10, 2018.

HYCF administration conducted comprehensive PREA training for all staff, including HYCF upper management and OYS Executive Director, on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which addressed all the deficiencies in staff training raised by this audit, including first responder training. The Auditor conducted telephonic interviews on December 5 and 10, 2018 with 15 random staff verifying their knowledge of the PREA standards and the quality of the PREA training they received. During telephonic interviews with random staff, all staff were able to articulate their duties as enumerated in this Standard. This standard is now fully compliant and the facility meets this standard.

## Standard 115.365: Coordinated response

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.26, *et seq.* and 12.12.4.10(b)
3. Draft PREA Incident Response Checklist form
4. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator

**Findings (By Subsection):**

Subsection (a): HYCF policy states that HYCF shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. HYCF has not developed a written institutional plan as outlined in the policy. HYCF P&P 12.12.4.10(b) states that staff shall completed the HYCF-200 Incident Report form and the HYCF PREA Incident Checklist for all allegations of sexual abuse and sexual harassment, contact the YFA and/or the agency Executive Director, and submit the completed forms to the PREA Coordinator. During the pre-audit, HYCF submitted a draft PREA Incident Response Checklist to ensure that all proper notifications and referrals in addition to key information about the incident that has not been trained on or implemented.

**Corrective Action:**

1. HYCF must finalize the draft PREA Incident Response Checklist that reflects a comprehensive and inclusive response protocol to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. All staff must be trained on this protocol to ensure true comprehension and working knowledge of the protocol. Documentation of training curriculum and training sign-in sheets for all staff must be submitted to the Auditor to demonstrate institutionalization of this standard requirement.

**Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on November 21 and 27, 2018, and December 4, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

**Additional Documentation Reviewed:**

1. Comprehensive PREA training was conducted at the facility which included initial training of HYCF upper management staff, including the OYS Executive Director, and HYCF trainers by The Moss Group. The Moss Group specifically tailored the PREA curriculum and training based on HYCF facility’s protocol and procedures, including PREA Incident Response Checklist that reflects a comprehensive and inclusive response protocol to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
2. Staff training sign-in sheets showing all staff, received this training on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which included training on utilization of the PREA Incident Response Checklist form and first responder duties.
3. The Auditor conducted telephonic interviews with random staff on December 5 and 10, 2018.

HYCF administration conducted comprehensive PREA training for all staff, including HYCF upper management and OYS Executive Director, on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which addressed all the deficiencies in staff training raised by this audit, including the PREA Incident Response Checklist that reflects a

comprehensive and inclusive response protocol to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The Auditor conducted telephonic interviews on December 5 and 10, 2018 with 15 random staff verifying their knowledge of the PREA standards and the quality of the PREA training they received. During telephonic interviews with random staff, all staff were able to articulate their duties as enumerated in this Standard. This standard is now fully compliant and the facility meets this standard.

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

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.366 (a)**

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?  Yes  No

#### **115.366 (b)**

- Auditor is not required to audit this provision.

### **Auditor Overall Compliance Determination**

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### **Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.27, *et seq.*
3. Collective Bargaining Agreements between Hawaii Employees Association and the United Public Workers, effective July 2013.
4. Interviews with the following:
  - a. Agency Head

### **Findings (By Subsection):**

Subsection (a): HYCF policy ensure that the agency or any other governmental entity responsible for collective bargaining on HYCF's behalf shall not enter into or renew any collective bargaining agreement or other agreement that limits HYCF's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. As part of the PAQ documentation, the Auditor was provided selective portions of 5 unit agreements related to the HYCF employees who

work directly with residents of the collective bargaining agreement between the Hawaii Employees Association and the United Public Workers, effective July 1, 2013 until June 30, 2017. The auditor verified with the agency Director that even though the contract has expired, it is still in effect until a new contract is approved and established. As of the date of the audit, a new agreement has not been reached and is still at an impasse. The Auditor did not find any language that limits or prohibits the facility from removing an alleged staff sexual abuser from contact with any resident pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted.

Subsection (b): N/A

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

**Corrective Action:** None.

## Standard 115.367: Agency protection against retaliation

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?  Yes  No
- Has the agency designated which staff members or departments are charged with monitoring retaliation?  Yes  No

#### 115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?  Yes  No

#### 115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No



- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks?  Yes  No

#### 115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?  Yes  No

#### 115.367 (f)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.28, *et seq.*
3. Review of the HYCF PREA Tracking Sheet
4. Interviews with the following:
  - a. Agency Head
  - b. Facility Head
  - c. Staff Member Charged with Monitoring Retaliation

d. Random Staff

**Findings (By Subsection):**

Subsection (a): HYCF has a policy protecting against retaliation. According to policy the YFA, Deputy YFA, and Correctional Supervisors are charged with monitoring any issues related to retaliation. At the time of the audit, the PREA Coordinator is the staff member in charge of monitoring. The YFA stated that he has communicated with staff that the safety of the child is important, and staff retaliation won't be tolerated. The YFA stated he will hold the CS1 and the YCS accountable for monitoring for retaliation. In the case of staff retaliation, the YFA stated the staff member would receive a cease and desist letter; and, in the worse-case scenarios, that staff could be placed on administrative leave or worse.

Subsection (b): HYCF's policy provides multiple measures to protect residents from retaliation, including housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff. The facility monitors retaliation monitoring on the HYCF PREA Tracking Sheet. The Auditor was provided a copy of this form during the audit.

Subsection (c): HYCF's policy requires the YFA or designee to monitor for at least 90 days the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act to promptly remedy any such retaliation. The PREA Coordinator stated he would monitor longer than the 90-day period. As of the date of the audit, the facility reported no incidents of retaliation have occurred within the past 12 months.

Subsection (d): In case of residents, HYCF's policy requires monitoring by the Correctional Supervisor and shall include periodic status checks, conducted weekly with a report submitted to the YFA or designee.

Subsection (e): HYCF's policy states the facility will take appropriate measures to protect other individuals to protect that individual against retaliation. The PREA Coordinator stated that he will personally check-in periodically with the individual involved to make sure that he/she is not experiencing any type of retaliation.

Subsection (f): HYCF policy provides that the YFA's or designee's obligation to monitor shall terminate if the investigation concludes that the allegation is unfounded.

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

**Corrective Action:** None.

**Standard 115.368: Post-allegation protective custody**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.368 (a)**

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?  Yes  No

**Auditor Overall Compliance Determination**

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

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

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.29, *et seq.*
3. Interviews with the following:
  - a. Facility Head
  - b. Staff Member Who Supervises Residents in Isolation
  - c. Medical and Mental Health Staff

**Findings (By Subsection):**

Subsection (a): The agency has a policy stating that any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subjected to the requirements of HYCF P&P 12.12.4.17, which corresponds to PREA Standard § 115.342. As of the date of the audit, the facility reported no resident who alleged to have suffered sexual abuse were placed in isolation within the past 12 months.

Interviews with facility head and staff who supervise residents in isolation indicate that isolation is seldom used at HYCF and not for residents who have alleged sexual abuse. Interviews with medical staff indicate that any resident in isolation is seen daily by the nurse and sometimes multiple times per day as needed. Mental health staff will also see residents in isolation as needed.

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

**Corrective Action:** None.

## INVESTIGATIONS

### Standard 115.371: Criminal and administrative agency investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### 115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA

**115.371 (b)**

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?  Yes  No

**115.371 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?  Yes  No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?  Yes  No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?  Yes  No

**115.371 (d)**

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?  Yes  No

**115.371 (e)**

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?  Yes  No

**115.371 (f)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?  Yes  No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?  Yes  No

**115.371 (g)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?  Yes  No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?  Yes  No

**115.371 (h)**

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?  Yes  No

**115.371 (i)**

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?  
 Yes  No

#### 115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?  Yes  No

#### 115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?  Yes  No

#### 115.371 (l)

- Auditor is not required to audit this provision.

#### 115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)  
 Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.30, *et seq.*
3. HYCF P&P 1.15, *et seq.*, Subject: *Administrative Investigations*
4. Review of Investigation files
5. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Investigator

#### Findings (By Subsection):

Subsection (a): HYCF conducts administrative investigations only, and criminal investigations are conducted by local law enforcement, which is usually the Honolulu Police Department. HYCF policies requires that administrative investigations are done so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Subsection (b): HYCF policies require the use of investigators who have received special training in sexual abuse allegations involving juvenile victims. The agency utilizes an Investigator who has received specialized training in sexual abuse allegation involving juveniles and sex trafficking.

Subsection (c): HYCF policy requires and the Investigator stated that he gathers and preserves direct and circumstantial evidence, including any available physical and DNA evidence; any available electronic monitoring data including surveillance monitors; communication logs; time cards; interviewing alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Subsection (d): HYCF policy prohibits termination of an investigation solely because the source of the allegation recants the allegation.

Subsection (e): HYCF policy states that when the quality of evidence appears to support criminal investigation, OYS/HYCF shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Subsection (f): HYCF policy states the credibility of an alleged victim, suspect or witness shall be assessed on an individual basis and shall not be determined merely by the person's status as a resident or staff member; and does not require a resident to submit to a polygraph examination, computer voice stress analysis (CVSA) or other truth-telling devices as a condition for proceeding with the investigation. OYS/HYCF staff may offer the victim or non-staff witness the option to participate in this type of technology process (polygraph, CVSA, or other truth-telling device). The Investigator stated he doesn't base the credibility of victim or witness based on whether that person is a resident or staff member. The investigator further stated that he does not utilize polygraph examination, CVSA or any other truth telling device during his investigations, and never would.

Subsection (g): HYCF policies tracks the requirements of this subsection of the Standard related to determining whether staff actions or failures to act contributed to the abuse and the documentation that must be maintained. The Auditor reviewed the confidential investigation files which are kept in the Investigator's office.

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

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

Subsection (j): HYCF policies track the requirements of this subsection of the Standard related to records retention and comply with this subsection.

Subsection (k): HYCF policy provides that the departure of the alleged abuser or victim from the employment or custody shall not provide a basis for terminating an investigation. The Auditor interviewed the Investigator who indicated that he would complete the investigation by formulating a conclusion that the allegation is substantiated, unsubstantiated, or unfounded even when the victim or abuser are no longer at HYCF.

Subsection (l): N/A

Subsection (m): HYCF policy requires facility staff to cooperate with outside investigators and shall endeavor to remain informed about the process of the outside agency's investigation.

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

Corrective Action: None.

## Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?  
 Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.31, *et seq.*
3. Interview with the following:
  - a. Investigator

### Findings (By Subsection):

Subsection (a): OYS/HYCF policy imposes a standard no higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. This was confirmed by the Auditor during the interview with the Investigator.

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

Corrective Action: None.

## Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.373 (a)

- Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?  Yes  No

### 115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)  Yes  No  NA

### 115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?  Yes  No

### 115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?  Yes  No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?  Yes  No

### 115.373 (e)

- Does the agency document all such notifications or attempted notifications?  Yes  No

### 115.373 (f)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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



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

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.32, *et seq.*
3. HYCF P&P 1.15, *et seq.*, Subject: *Administrative Investigations*
4. DHS Form 0615 – Notification of Status
5. Review of Investigation Files
6. HYCF PREA Tracking Sheet
7. Interviews with the following:
  - a. Facility Head
  - b. Investigator
  - c. PREA Coordinator

**Findings (By Subsection):**

Subsection (a): HYCF policy requires notification to the resident as to whether the administrative or criminal allegation has been determined to be substantiated, unsubstantiated or unfounded. During the pre-audit, the Auditor was provided a copy of DHS Form 0615 – Notification of Status which is used to notify the resident of the outcome of the administrative and criminal investigation. The facility reports in the PAQ that four administrative investigations were completed by the facility in the past 12 months, and the four residents received notification verbally and in writing of the results of the investigation. The Auditor interviewed the Investigator and PREA Coordinator who both indicated the practice is to notify the resident as required by this subsection. The Auditor reviewed the investigation files which included written notification of the results of their investigation.

Subsection (b): HYCF policy ensures that HYCF shall request the relevant information from the outside investigative agency in order to inform the resident. The facility reports in the PAQ that in the past 12 months there have been no criminal cases referred for prosecution.

Subsection (c): HYCF P&P 12.12.4.32(c) details the required notifications pursuant to this subsection of the Standard.

Subsection (d): HYCF P&P 12.12.4.32(d) details the required notifications pursuant to this subsection of the Standard.

Subsection (e): HYCF policy requires documentation, utilizing the Internal Communications Form with a subject line of Notification Status, of all notifications or attempted notifications to the resident victim and a copy forwarded to the PREA Coordinator within three days. The facility reports in the PAQ that four residents received notification verbally and in writing of the results of the investigation. A review of the investigation files showed where the resident received written notification of the outcome of their investigation

Subsection (f): N/A

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

**Corrective Action:** None.

# DISCIPLINE

## Standard 115.376: Disciplinary sanctions for staff

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?  Yes  No

#### 115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?  Yes  No

#### 115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?  Yes  No

#### 115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)?  Yes  No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

- HYCF Completed Pre-Audit Questionnaire ("PAQ")
- HYCF P&P 12.12.4.33, *et seq.*
- Interviews with the following:
  - PREA Coordinator
  - Human Resources Staff

## Findings (By Subsection):

Subsection (a): HYCF policy states that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Subsection (b): HYCF policy states that termination shall be the presumptive disciplinary sanction for all staff that, after an investigation and a pre-disciplinary due process hearing, have been found to have engaged in sexual abuse. The facility reports in the PAQ that no staff from the facility have been terminated or resigned prior to termination for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

Subsection (c): HYCF policy states that disciplinary sanctions for violations of HYCF policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar employment histories. The facility reports in the PAQ that no staff from the facility has been disciplined, short of termination for violation of agency sexual abuse or sexual harassment policies in the past 12 months.

Subsection (d): HYCF provides that all terminations for violations of sexual abuse or sexual harassment within HYCF policies, or resignations by staff who would have been terminated, if not for their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, as well as to any relevant licensing bodies.

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

**Corrective Action:** None.

## Standard 115.377: Corrective action for contractors and volunteers

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?  
 Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?  
 Yes  No

#### 115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?  Yes  No

### Auditor Overall Compliance Determination

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

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

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.34, *et seq.*
3. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator

**Findings (By Subsection):**

Subsection (a): HYCF policy requires that a contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. As of the date of the audit, the facility reported in the PAQ that no contractor and/or volunteer have been reported to law enforcement agencies or licensing bodies for engaging in sexual abuse of a resident in the past 12 months.

Subsection (b): HYCF policy states HYCF shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of HYCF sexual abuse and sexual harassment policies by a contractor or volunteer.

During the interview with the YFA and the PREA Coordinator, the Auditor confirmed that the facility is following the subsections of this Standard and HYCF policy.

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

Corrective Action: None.

## **Standard 115.378: Interventions and disciplinary sanctions for residents**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.378 (a)**

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?  Yes  No

#### **115.378 (b)**

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?  Yes  No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?  Yes  No

**115.378 (c)**

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?  Yes  No

**115.378 (d)**

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?  Yes  No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?  Yes  No

**115.378 (e)**

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?  Yes  No

**115.378 (f)**

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?  Yes  No

**115.378 (g)**

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)  Yes  No  NA

**Auditor Overall Compliance Determination**

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

## **Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.35, *et seq.*
3. HYCF P&P 15.01, *et seq.*, *Subject: Discipline System Overview*
4. HYCF P&P 16.01, *et seq.*, *Subject: Due Process Hearing*
5. Interviews with the following:
  - a. Facility Head
  - b. Medical and Mental Health Staff

## **Findings (By Subsection):**

Subsection (a): HYCF P&P 12.12.4.35 states that residents are subject to disciplinary sanctions only pursuant to a formal due process hearing following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. As of the date of the audit, the facility reported in the PAQ that there have been no administrative or criminal findings of guilt of resident-on-resident sexual abuse in the past 12 months.

Subsection (b): HYCF policy provides that residents may be subject to disciplinary sanctions only pursuant to a formal disciplinary process. Disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident’s behavioral history, and the sanctions imposed for comparable offense by other youth with similar histories. If the due process hearing results in the isolation of a resident, the resident shall be afforded daily large-muscle exercise; shall have access to any legally required educational programming or special education services; shall receive daily visits from a medical or mental health care clinician; and shall also have access to other programs and work opportunities to the extent possible. As of the date of the audit, the facility reported in the PAQ that no resident has been placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse in the past 12 months.

Subsection (c): HYCF policy states the due process hearing, in conjunction with the Treatment Team process, shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanctions, if any, should be imposed. This practice was confirmed by the YFA.

Subsection (d): HYCF policy addressed the requirements of this subsection regarding offering therapy, counseling or other interventions to residents as part of the discipline. HYCF may require participation in such participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education. Interviews with medical and mental health staff indicate the practice is compliant with this subsection.

Subsection (e): HYCF policy permits sanctions on residents for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Subsection (f): HYCF policy prohibits any sanctions for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Subsection (g): HYCF prohibits all sexual activity between residents and may sanction a resident for such activity; and shall deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

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

**Corrective Action:** None.

## MEDICAL AND MENTAL CARE

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

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?  Yes  No

#### 115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?  Yes  No

#### 115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?  Yes  No

#### 115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.36, *et seq.*
3. On-site review of administrative area where resident files are stored to determine security of records
4. Interviews with the following:
  - a. Medical and Mental Health Staff
  - b. Staff Responsible for Risk Screening – Social Workers

## Findings (By Subsection):

Subsection (a): HYCF policy states that staff will ensure that a resident is offered a follow-up meeting with medical or mental health practitioner within 14 days of intake screening if screening indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community. As of the date of the audit, the facility reported in the PAQ that no resident has disclosed prior victimization during screening within the past 12 months. Interviews with medical and mental health staff indicate that the facility practice would be for the nurse to see a resident upon arrival, especially when the screening process indicates prior sexual victimization upon referral from the resident's Social Worker. The facility utilizes the information from YASI and HYCF Housing Assessment for referrals.

Subsection (b): HYCF policy states that staff will ensure that a resident is offered a follow-up meeting with medical or mental health practitioner within 14 days of intake screening if screening indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community. As of the date of the audit, the facility reported in the PAQ that no resident has disclosed previously perpetrated sexual abuse during screening within the past 12 months. Interviews with medical and mental health staff indicate that the facility practice would be for the nurse to see a resident almost immediately upon arrival when the screening process indicates prior sexual victimization upon referral from the resident's Social Worker. Medical staff is available 24/7 and they would call Crisis Mobile Outreach if mental health staff is not available. The facility utilizes the information from YASI and HYCF Housing Assessment for referrals.

Subsection (c): HYCF policy provides that the information gained at intake screening is confidential and strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions. During the on-site audit, the Auditor was shown where residents' medical files are located in the medical area and their screening files are securely located in the administration office requiring supervisory approval for access for the reasons outlined in this subsection.

Subsection (d): HYCF policy requires medical and mental health practitioners to obtain informed consent from residents over the age of 18 before reporting information about prior sexual victimization that did not occur in an institutional setting. Interviews with medical and mental health staff indicate that they obtain the consent using the HYCF Consent to Treatment and Medication Terms and Conditions of Service form.

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

**Corrective Action:** None.

## Standard 115.382: Access to emergency medical and mental health services

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?  Yes  No

#### 115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?  Yes  No



- Do staff first responders immediately notify the appropriate medical and mental health practitioners?  
 Yes  No

#### 115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?  Yes  No

#### 115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

#### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.37, *et seq.*
3. Interviews with the following:
  - a. Medical and Mental Health Staff
  - b. Security First-Responders and non-Security Staff

#### Findings (By Subsection):

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

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

Subsection (c): HYCF policy ensure that resident victims of sex abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care where medically appropriate.

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

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

**Corrective Action:** None.

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

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?  
 Yes  No

#### 115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?  Yes  No

#### 115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care?  Yes  No

#### 115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)  Yes  No  NA

#### 115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)  Yes  No  NA

#### 115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?  Yes  No

#### 115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?  Yes  No

#### 115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?  Yes  No

### Auditor Overall Compliance Determination

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

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

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

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.38, *et seq.*
3. Interviews with the following:
  - a. Medical and Mental Health Staff

**Findings (By Subsection):**

Subsection (a): HYCF policy states that HYCF shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any juvenile detention or juvenile facility.

Subsection (b): HYCF policy states that the resident shall receive the evaluation and treatment, follow-up services, treatment plans, and when necessary, referrals for continued care, following their transfer to, or placement in, other facilities or their release from custody.

Subsection (c): HYCF policy ensures they shall provide victims with medical and mental health services consistent with the community level of care.

Subsection (d): HYCF policy states that resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy test.

Subsection (e): HYCF policy states that if pregnancy results from sexually abusive vaginal penetration while incarcerated at HYCF, the victim shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Subsection (f): HYCF policy ensures that resident victims of sexual abuse while incarcerated at HYCF shall be offered tests for sexually transmitted infections as medically appropriate

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

Subsection (h): HYCF policy states HYCF, through the Family Court Liaison Branch (FCLB), shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning such abuse history and offer treatment when deemed appropriate by mental health practitioners.

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

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

Corrective Action: None.

## DATA COLLECTION AND REVIEW

### Standard 115.386: Sexual abuse incident reviews

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?  Yes  No

#### 115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation?  Yes  No

#### 115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?  Yes  No

#### 115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

#### 115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so?  Yes  No

## Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.39, *et seq.*
3. Interviews with the following:
  - a. Facility Head
  - b. PREA Coordinator
  - c. PREA Compliance Manager
  - d. Member of Sexual Abuse Incident Review Team

### Findings (By Subsection):

Subsection (a): HYCF policy requires HYCF to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegations has not been substantiated, unless the allegations has been determined to be unfounded. The facility reported in the PAQ that only two of the four administrative investigations reported in the PAQ § 115.322 were reviewed by the facility, not the sexual abuse incident review team (“review team”), in the past 12 months. Interview with the YFA confirmed that HYCF does not have a sexual abuse incident review team as set forth in HYCF policy and this Standard.

Subsection (b): HYCF policy states the review shall ordinarily occur within 30 days of the conclusion of the investigation. The facility reported in the PAQ that of the four administrative investigations of alleged sexual abuse in the past 12 months, two were unfounded and two were reviewed by management. During the pre-audit the Auditor was informed that the process is not in place to ensure a review of every administrative investigation of an allegation of sexual abuse, and staff have not been trained to review every administrative investigation of alleged sexual abuse.

Subsection (c): HYCF policy states that the incident review team shall include upper-level management officials, with input from line supervisors, investigators, and medical and mental health practitioners. The Auditor was informed during the pre-audit that the HYCF review team members are the CS1s and YCSs; however, there was no mention regarding whether the review team would also include as members or input from the Investigator or medical/mental health staff.

Subsection (d): HYCF policy details all the items that the review team must consider when conducting the review and the policy is compliant with the Standard requirement. During the pre-audit the Auditor was informed that there were no minutes or other form of documentation showing the review team met and the outcome of their meeting. HYCF Policy requires the written report to be submitted to the YFA and PREA Coordinator upon completion. During the on-site audit the Auditor spoke with several CS1s and YCSs who were unaware that the HYCF policy created a review team; they were not aware of the existence of a review team; they were not aware they could be asked to sit as a member of this review team; they were not aware of their duties or responsibilities as members of the review team; and they had not received any written protocol or training on the duties of the review team as set out in this Standard.

Subsection (e): HYCF policy states that the YFA shall employ “best efforts” to implement the recommendations for improvement or shall document its reasons for not doing so.

### Corrective Action:

1. HYCF administration must finalize a protocol and written form to be utilized by the sexual abuse incident review team reflecting the date of the meeting; those attending the meeting; whether the sexual abuse incident review team received input from line supervisors, investigators, and medical and mental health care practitioners; and that the sexual abuse incident review team considered all the items set out in the subsection of § 115.386(d), including preparing a written report of its findings. The finalized plan and any documents that are incorporated into or with the plan must be resubmitted to the Auditor.
2. All staff who are eligible to be members of the sexual abuse incident review team must be trained on this protocol to ensure true comprehension and working knowledge of this Standard. Documentation of this training must be submitted to the Auditor to demonstrate institutionalization of this Standard requirement.

### Verification of Corrective Action since the Audit:

The Auditor was provided supplemental documentation on November 21 and 27, 2018, and December 4, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

### Additional Documentation Reviewed:

1. Comprehensive PREA training was conducted at the facility which included initial training of HYCF upper management staff, including the OYS Executive Director, and HYCF trainers by The Moss Group. The Moss Group specifically tailored the PREA curriculum and training based on HYCF facility's protocol and procedures, including protocols for the sexual abuse incident review team.
2. Staff training sign-in sheets showing all staff, received this training on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which included training on the sexual incident review team.
3. The Auditor conducted telephonic interviews with specialized staff on December 5 and 10, 2018.

HYCF administration conducted comprehensive PREA training for all staff, including HYCF upper management and OYS Executive Director, on October 30, 2018, and November 6, 8, 13, 15, 20, 26, and 30, 2018 which addressed all the deficiencies in staff training raised by this audit, including the sexual abuse incident review team. The Auditor conducted telephonic interviews on December 5 and 10, 2018 with specialized staff verifying their knowledge of the PREA standards and the quality of the PREA training they received. During telephonic interviews with staff, staff were able to articulate their duties as members of the sexual abuse incident review team. This standard is now fully compliant and the facility meets this standard.

## Standard 115.387: Data collection

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?  Yes  No

#### 115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?  Yes  No

### 115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?  
 Yes  No

### 115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?  Yes  No

### 115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)  Yes  No  NA

### 115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)  
 Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.40, *et seq.*
3. Documentation showing data collection
4. Interviews with the following:
  - a. Agency Head
  - b. Facility Head
  - c. PREA Coordinator

### Findings (By Subsection):

Subsection (a): HYCF policy requires the facility to collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions.

Subsection (b): HYCF policy states HYCF shall aggregate the incident-based sexual abuse data at least annually.

Subsection (c): HYCF policy states that the incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

Subsection (d): HYCF policy requires the facility to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews. HYCF does not have a sexual abuse incident review team as required by the Standards.

Subsection (e): HYCF does have a policy to obtain incident-based and aggravated data from private facility with which it contracts for the confinement of its residents. The Auditor was informed that HYCF does not contract for the confinement of its residents.

Subsection (f): Upon request, HYCF shall provide all such data from the previous calendar year to the Department of Justice no later than June 30<sup>th</sup>. The facility reported in the PAQ that the Department of Justice has not requested data from the agency. A copy of the agency's reports are available on the agency's website at <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>

#### **Corrective Action:**

1. HYCF administration must consider the recommendations of the sexual abuse incident review team as set out in Standard § 115.386 as part of the to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews including preparing a written report of its findings. The finalized plan and any documents that are incorporated into or with the plan must be resubmitted to the Auditor.

#### **Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 2, 2018 and November 20, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

#### **Additional Documentation Reviewed:**

1. Documentation showing that HYCF has created a spreadsheet that has collected the data from 2013 thru 2017 as required by this Standard, and reflected in the 2017 Annual Report published on the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>.

HYCF administration maintains, reviews and collects data as needed from all available incident-based documents, including recommendations from the sexual abuse incident review team. This standard is now fully compliant and the facility meets this standard.

## **Standard 115.388: Data review for corrective action**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.388 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?  Yes  No



- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?  Yes  No

#### 115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?  Yes  No

#### 115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?  Yes  No

#### 115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire ("PAQ")
2. HYCF P&P 12.12.4.41, *et seq.*
3. Interviews with the following:
  - a. Agency Head
  - b. Facility Head
  - c. PREA Coordinator
  - d. PREA Compliance Manager

### Findings (By Subsection):

Subsection (a): HYCF policy states that HYCF shall review data collected and aggregated pursuant to § 4.40 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: (1) identifying problem areas; (2) taking corrective action on an ongoing basis; and (3) preparing an annual report of its findings and corrective actions for HYCF, as well as OYS as a whole. The Auditor was informed by the PREA Coordinator during the pre-audit that no annual report has been formulated as required by this Standard and HYCF policy. The OYS Executive Director stated to the Auditor that a review of the collected data would show if there are any patterns in the deficiencies; reviewing specific incidents looking for areas to improve coverage in order to protect

residents and staff; reviewing staffing patterns to improve awareness and monitoring the security needs at the facility; and reviewing and evaluating current policies and procedures in order to prevent sexual abuse.

Subsection (b): HYCF policy states that such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

Subsection (c): HYCF policy states that the report shall be approved by the Executive Director and made readily available to the public through its website or, if it does not have one, through other means. The OYS Executive Director stated he has not approved any written report as required by this Standard.

Subsection (d): HYCF policy states that HYCF may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

**Corrective Action:**

1. HYCF must develop and finalize a written annual report as required by this Standard, including all subsections, and HYCF policy 12.12.4.41.
2. This annual report must be made available to the public through the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/> or through other means.

**Verification of Corrective Action since the Audit:**

The Auditor was provided supplemental documentation on August 2, 2018 and November 20, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

**Additional Documentation Reviewed:**

1. Documentation showing that HYCF has created a spreadsheet that collected the data from 2013 thru 2017 as required by this Standard and reflected in the 2017 Annual Report published on the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>.

OYS and HYCF administration completed and finalized their annual report, and has made the report available to the public on the website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>. This standard is now fully compliant and the facility meets this standard.

**Standard 115.389: Data storage, publication, and destruction**

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.389 (a)**

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?  
 Yes  No

**115.389 (b)**

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?  Yes  No

### 115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?  Yes  No

### 115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.42, *et seq.*
3. Interviews with the following:
  - a. Agency Head
  - b. Facility Head
  - c. PREA Coordinator

### Findings (By Subsection):

Subsection (a): HYCF policy ensures that data collected pursuant to § 4.40 are securely retained.

Subsection (b): HYCF policy states that OYS/HYCF shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means. HYCF has not collected, aggregated, analyzed and made this data available to the public through its website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/> or any other public means.

Subsection (c): HYCF policy states that before making aggregated sexual abuse data publicly available, HYCF shall remove all personal identifiers and comply with HRS§ 92(F), Uniform Information Practices Act (Modified).

Subsection (d): HYCF policy states that the facility shall maintain sexual abuse data collected pursuant to § 4.40 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

### Corrective Action:

1. HYCF must complete its data collection, aggregation, and analysis. HYCF must finalize the annual report as required by the Standards, and submit a copy the annual report to the Auditor.
2. This annual report must be made available to the public through the agency’s website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/> or through other means, and provided to the Auditor.

### Verification of Corrective Action since the Audit:

The Auditor was provided supplemental documentation on August 2, 2018 and November 20, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

### Additional Documentation Reviewed:

1. Documentation showing that HYCF has created a spreadsheet that collects the data from 2013 thru 2017 as required by this Standard and reflected in the 2017 Annual Report published on the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>.

OYS and HYCF administration completed and finalized their annual report, and has made the report available to the public on the website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>. This standard is now fully compliant and the facility meets this standard.

## AUDITING AND CORRECTIVE ACTION

### Standard 115.401: Frequency and scope of audits

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once?  Yes  No

#### 115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited?  Yes  No

#### 115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?  
 Yes  No

#### 115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?  Yes  No

#### 115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?  
 Yes  No

## 115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Evidence Reviewed (documents, interviews, site review):

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. HYCF P&P 12.12.4.44, *et seq.*
3. Interviews with the following:
  - a. Agency Head
  - b. Facility Head
  - c. PREA Coordinator

### Findings (By Subsection):

Subsection (a): HYCF policy states that OYS/HYCF shall conduct audits during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency will make its best efforts to ensure that each facility operated by OYS, or by a private organization on behalf of OYS, is audited at least once. In their PAQ, OYS and HYCF reported has not undergone a PREA audit before this audit.

Subsection (b): HYCF policy states that during each one-year period starting August 20, 2013, OYS shall make its best efforts to ensure that at least one-third of each facility type operated by OYS, or by a private organization on behalf of OYS, is audited.

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

Subsection (i): HYCF policy does not address this subsection. During the audit, the Auditor requested and received copies of all relevant documents, including electronically stored information, as required by the Standards.

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

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

The best practice would be for the agency to modify HYCF P&P 12.12.4.44, *et seq.*, to reflect the addition of subsections (h), (i), (m), and (n) of this Standard 115.401 into their policy.

### Corrective Action:

1. OYS must outline a plan moving forward to meet the standard by having the facility audited every three years in a timely manner, and submit documentation of same to the Auditor.
2. OYS/HYCF must revise HYCF P&P 12.12.4.44, *et seq.*, to reflect the addition of subsections (h), (i), (m), and (n) of Standard 115.401 into their policy, and submit documentation showing these revisions to the Auditor.

### Verification of Corrective Action since the Audit:

The Auditor was provided supplemental documentation on August 2, 2018 and November 20, 2018 to evidence and demonstrate corrective action taken by HYCF administration regarding this standard. This documentation is discussed below.

### Additional Documentation Reviewed:

1. Revised HYCF P&P 12.12.4.44, *et seq.*, Frequency and Scope of Audits.
2. Documentation outlining the proposed PREA audits beginning in 2019 thru August of 2026 and published on the agency's website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>.

HYCF administration completed and finalized revise HYCF P&P 12.12.4.44, *et seq.*, to reflect the addition of subsections (h), (i), (m), and (n) of Standard 115.401 into their policy. HYCF administration completed and finalized the proposed PREA audit schedule in Internal Communication Form dated November 16, 2018, which is available to the public on the website <http://humanservices.hawaii.gov/oys/hawaii-youth-correctional-facility/>. This standard is now fully compliant and the facility meets this standard.

## Standard 115.403: Audit contents and findings

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)  
 Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

**Evidence Reviewed (documents, interviews, site review):**

1. HYCF Completed Pre-Audit Questionnaire (“PAQ”)
2. Interviews with the following:
  - a. Agency Head
  - b. PREA Coordinator

**Findings (By Subsection):**

Subsection (f): The agency/facility has not undergone an audit before, and no Final Audit Report has been issued.

**Corrective Action:** None

<b>AUDITOR CERTIFICATION</b>
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I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

*Sharon G. Robertson*

Sharon G. Robertson  
**Auditor Signature**

December 31, 2018  
**Date**