# PREA AUDIT REPORT ☐ Interim ☒ Final

# COMMUNITY CONFINEMENT FACILITIES

**Date of report:** October 20, 2015

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| **Auditor Information** |
| **Auditor name:** Richard McVicar |
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| **Email:** Richard.McVicar@NakamotoGroup.com |
| **Telephone number:** 618-579-6406 |
| **Date of facility visit:** September 28 – 29, 2015 |
| **Facility Information** |
| **Facility name:** Kintock Newark Complex |
| **Facility physical address:** 50 Fenwick, Newark, NJ 07114 |
| **Facility mailing address:** *(if different from above)* Click here to enter text. |
| **Facility telephone number:** 973-622-1400 |
| **The facility is:** | ☐ Federal | ☐ State | ☐ County |
| ☐ Military | ☐ Municipal | ☐ Private for profit |
| ☒ Private not for profit |
| **Facility type:** | ☒ Community treatment center☒ Halfway house☐ Alcohol or drug rehabilitation center | ☐ Community-based confinement facility☐ Mental health facility ☐ Other |
| **Name of facility’s Chief Executive Officer:** Gregory Bartkowski |
| **Number of staff assigned to the facility in the last 12 months:** 103 |
| **Designed facility capacity:** 578 |
| **Current population of facility:** 364 |
| **Facility security levels/inmate custody levels:** minimum |
| **Age range of the population:** Adult - 18 and over |
| **Name of PREA Compliance Manager:** Click here to enter text. | **Title:** Click here to enter text. |
| **Email address:** Click here to enter text. | **Telephone number:** Click here to enter text. |
| **Agency Information** |
| **Name of agency:** The Kintock Group Newark, NJ |
| **Governing authority or parent agency:** *(if applicable)* The Kintock Group of New Jersey |
| **Physical address:** 580 Virginia Drive, Suite 250 Fort Washington, PA 19034 |
| **Mailing address:** *(if different from above)* Click here to enter text. |
| **Telephone number:** 610-687-1336 |
| **Agency Chief Executive Officer** |
| **Name:** Diane DeBarri | **Title:** Chief Executive Officer |
| **Email address:** Diane.DeBarri@kintock.org | **Telephone number:** 610-687-1336 |
| **Agency-Wide PREA Coordinator** |
| **Name:** Nicola Cucinotta | **Title:** Corporate Director of Public Affairs and Information |
| **Email address:** nicola.cucinotta@kintock.org | **Telephone number:** 610-724-8365 |

# AUDIT FINDINGS

## NARRATIVE

This PREA audit began on the morning of September 28th, 2015 in Building 3 of the Kintock Newark Residential complex. This auditor met with corporate executive staff as well as facility administrative staff to discuss the audit, the tour, and my intended schedule over the course of this two day audit. During this initial meeting I also had the opportunity to meet additional key staff at the facility. This provided the opportunity for me to gain a better understanding of the facility, as well as the opportunity for personnel to ask questions about the audit process. I proceeded on a tour of the facility after the initial meeting. I was accompanied by both corporate and administrative staff. During the tour I had opportunity to view all residential, operational, program, and common areas of the facility. I had opportunity to meet informally with multiple residents, both individually and in small groups. Without exception, residents indicated that they felt safe at this facility. Residents had a good understanding of PREA and, when asked, provided this auditor with resident handbooks and handouts (with applicable PREA information) provided to them at intake. Residents indicated that security staffing at the time of audit was normal. Residents who were in the process of working indicated that their direction came from staff and not from other residents. PREA signage throughout the complex was good and referenced hot-line numbers for the New Jersey State Ombudsmen as well as SAVE (Rape Crisis Center). There were multiple telephones dedicated to resident use in day room areas. This auditor did pick one phone at random and called the "posted" SAVE number and was connected to a rape crisis counselor. Staffing appeared to be adequate for the type of facility and level of security of this complex. I had opportunity to meet informally with staff and ask questions regarding PREA and their responsibilities. Responses were appropriate. The overall mood of the resident population was positive. Staff morale was viewed as good. Security staffing is complemented by an extensive camera surveillance system and it is clear that thought has been put in to camera placement. Facility staff are to be complemented for maintaining this aging physical plant in a manner that demonstrates an appreciation for good housekeeping and maintenance. The facility does have two holding cells, both unoccupied. Should they be used, it would be short term until transportation is available. Occupants would be under constant staff supervision. There is a medical exam room staffed by one contractual nurse. All clinical and medical file cabinets viewed during the facility tour had adequate safeguards to ensure the integrity of contents. After the tour I worked with administrative personnel to identify both random staff and residents for purposes of formal interviews. This auditor was advised that there were no residents assigned to the facility who met criteria for a targeted interview (transgender, intersex, assault victim, language barrier, or special request for interview). Interviews proceeded during the afternoon and in to day two of the audit. This auditor met with executive staff on day two to discuss audit concerns or needs. Kintock staff were responsive to any needs this auditor expressed. This auditor reviewed HR files for random staff as well as master files for random residents on day two. An informal closeout session with executive Kintock staff brought the on-site portion of the audit to a close.

**DESCRIPTION OF FACILITY CHARACTERISTICS**

The physical plant of this facility was built approximately eighty years ago for commercial use (meat packing). The site was renovated in 1993 to serve its present function as a residential community correctional facility. The residential complex consists of two buildings identified as building 1 and building 3. The population in building 1 at the time of audit was 292. That population is all male and all are clients of the New Jersey Department of Corrections. Building 3 is a co-ed residential facility with a count at the time of audit of seventy two (72). Sixteen (16) of that number are female and the remaining fifty six (56) are male. Females are housed in two dormitories with appropriate sight and sound separation from the male population. Building 3 houses clients from both NJDOC as well as the New Jersey Parole Authority. Both buildings have dedicated kitchen and dining areas. Building one has a video surveillance system employing forty four (44) surveillance cameras with DVR capabilities providing an approximate two (2) week backup. Building 3 has thirty two (32) cameras with similar backup capabilities. Cameras for both buildings include both fixed and pan capabilities and are monitored at respective control rooms in both facilities. Building 1 has a complement of eleven (11) security staff and building 3 has seven (7). Deployment of staff is well thought out and ensures appropriate 24 hour supervision in dormitories, common areas, and control areas. Facility programming is inclusive of a work release operation, drug treatment, and re-entry counseling. The physical plant is in relatively good repair given the age and use condition of the facility. It is obvious that emphasis is placed on good housekeeping practices. The Kintock Newark Residential Center is accredited by the American Correctional Association.

**SUMMARY OF AUDIT FINDINGS**

There are 39 PREA standards established for Community Based Confinement Facilities. The Kintock Newark Complex was audited on September 28 - 29 of this year. Four (4) standards were not applicable. The facility met the requirements of twenty nine (29) standards. The facility substantially exceeded the requirements of six (6) standards. This should be considered a final report. The Kintock Newark Complex has met or exceeded all applicable standards and is recommended for PREA certification accordingly.

Number of standards exceeded: 6

Number of standards met: 29

Number of standards not met: 0

Number of standards not applicable: 4

**Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 1 - 11 satisfies all elements relevant to part (a) of this standard. The policy details a zero tolerance policy as well as procedure that serves to prevent, detect, and respond to incidents of sexual harassment and abuse. Kintock Group has designated a Corporate Director as the agency PREA coordinator. The PREA coordinator reports directly to the agency Chief Operating Officer. The agency corporate table of organization as well as staff interviews serve to support compliance. The facility meets this standard.

**Standard** **115.212 Contracting with other entities for the confinement of residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility is a private not for profit operation. Kintock Group contracts with the New Jersey Department of Corrections and the New Jersey Parole Authority to house and provide re-entry programming for its clients. This standard is not applicable.

**Standard 115.213 Supervision and monitoring**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility has an adequate staffing plan for supervision of their resident population. There are eighteen staff with direct supervision responsibilities. Eleven of these staff are deployed on a 24 hour basis in building one and the remaining seven in building three. Vacancies in direct supervision posts are remedied via re-assignment of staff or utilization of overtime. Direct supervision staff are complemented by an extensive video surveillance system with DVR capability. Kintock group does an annual review and assessment of both security staffing and monitoring systems in a manner consistent with the requirements of this standard. The last such review was conducted on July 8th of this year. The facility meets this standard.

**Standard 115.215 Limits to cross-gender viewing and searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility standard operating procedure (SOP) # 16, part D, pg. 4 prohibits strip and body cavity searches. Policy 11.08, pg. 7 stipulates that in the event strip search is warranted, the facility must request of the contracting authority that their (contracting authority) staff perform the strip search. Policy 3.05, pg. 4 prohibits cross gender searches. There have been no documented occurrences of strip searches, body cavity, or cross gender searches this past reporting period. Policy 3.05, pg. 4 also prohibits gross gender strip searches and body cavity searches. Policy 8.02, pg. 1 addresses resident privacy stipulations as identified in part (d) of this standard. Policy 11.08, pg. 1 prohibits the search or physical examination of a transgender or intersex resident for purposes of identifying genital status. Training curriculum and records support part (f) of this standard in relative to performing searches of transgender and intersex residents. Random interviews support compliance. The facility meets this standard.

**Standard 115.216 Residents with disabilities and residents who are limited English proficient**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 15.01 pg. 2 and policy 3.05 pg. 7 both serve to support compliance with parts (a) and (b) of this standard regarding the facilities obligation to ensure that residents with disabilities or who have limited English proficiency have meaningful access to all aspects of the facilities program to prevent, detect, and respond to sexual abuse and harassment. Staff training curriculum, training records, handbook, and other bi-lingual materials reviewed by this auditor support compliance. Policy 3.05, pg. 5 provides language that prohibits the use of resident interpreters as stipulated in part (c) of the standard. The facility utilizes bi-lingual staff as interpreters. The facility meets this standard.

**Standard 115.217 Hiring and promotion decisions**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.11, pg. 2 addresses Kintock Group personnel policy relative to hiring and promotional requirements. The policy prohibits hiring or promoting employees and prohibits enlisting the services of any contractor who may have contact with residents should they have a history of sexual abuse or other prohibitions as referenced in part (a) of this standard. A random personnel file review as well as staff interviews reflect compliance with both parts (a) and (b) of this standard. Policy 3.11, pg. 1 requires criminal background checks of potential new employees and contractors as specified by parts (c) and (d) of this standard. While the contracting authority performs such background checks, the facility goes a step further by contracting with a private background check service that specifically reviews PREA related histories as required by this standard. Kintock Group HR Policy regarding recruitment, pg. 14 requires PREA adherence with regard to hiring and background checks. Employment and promotional examinations require the applicant to declare previous misconduct as stipulated by this standard. A random file review supports compliance with parts (f) and (g) of this standard. The facility exceeds the requirements of this standard and is rated accordingly.

**Standard 115.218 Upgrades to facilities and technologies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has had no substantial modification or renovation this past reporting period. The surveillance system has been upgraded via addition of several new cameras (some with pan capability), repositioning existing cameras, and enhancement of DVR capabilities. Changes to the surveillance system were prompted by the annual PREA review and were well documented. The facility meets this standard.

**Standard 115.221 Evidence protocol and forensic medical examinations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct criminal or administrative investigations. Such investigations are referred to appropriate authority. If authorized by the contracting authority, the facility will transport residents to Beth Israel Hospital in Newark which provides SAFE / SANE care and forensic services. The facility maintains a memorandum of understanding with SAVE of Family Service League, Inc. which provides (among other services) a rape advocacy service. SAVE would be notified that the victim is being transported to Beth Israel Hospital and would deploy a qualified staff members to provide protocols consistent with the requirements of part (d) and (e) of the standard. Kintock Group has requested that NJDOC and NJ Parole Authority conduct investigations in a manner consistent with this standard. NJDOC policy supports compliance. Staff interviews support compliance. The facility meets this standard.

**Standard 115.222 Policies to ensure referrals of allegations for investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 7 requires that incidents involving program participants referred by NJDOC will be referred to and investigated by NJDOC Special Investigations Division (SID). For incidents involving non NJDOC residents the contractor shall be notified immediately and the incident will be referred to the local community Special Victims Unit for investigation. The facility reports no referrals this past reporting period. Kintock Group has published their policy on the corporate web site. The facility meets this standard.

**Standard 115.231 Employee training**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Kintock Groups Annual Training Policy 4.04 addresses all ten areas of training identified in part (a) of this standard. The policy (4.04, pg. 2) also requires that the training be tailored to the gender of the residents at the facility and that employees receive required annual training with updates as warranted. Employee training documents were reviewed and the training certification includes a signed acknowledgment of both training and that the training was understood. The training curriculum and power point presentation were reviewed and serve to support compliance. The facility has an exceptional training plan and delivery system. Random staff interviews represent a well-trained staff. The facility exceeds this standard.

**Standard 115.232 Volunteer and contractor training**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 4.05, pg. 1 requires that contract personnel receive annual training regarding their responsibility as it relates to the prevention, detection, and responses to sexual abuse and harassment. The policy further requires that volunteers and contractors shall be trained according to the level of contact they have with residents. Minimally, the facility requires that all volunteers and contractors who have contact with residents will be notified of the zero tolerance policy and informed of how to report such incidents. Notifications and training are to be acknowledged by signature, indicating that the training was received and understood. Staff interviews and file reviews support compliance. The facility exceeds this standard.

**Standard 115.233 Resident education**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 6 - 7, provides language that supports compliance with all components of this standard. The resident handbook as well as other resident training materials were reviewed and support compliance. Bi-lingual signage was well displayed and residents appeared to have an adequate knowledge of PREA in both informal and random interviews. Documentation of resident participation in education sessions was reviewed and supports compliance. The facility meets this standard.

**Standard 115.234 Specialized training: Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct any form of investigation relative to sexual abuse or sexual harassment involving the resident population. Such incidents are referred to proper investigative authority. This standard is not applicable to the facility.

**Standard 115.235 Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility does have a contractual nurse and a part time psychiatrist on site. A small exam room is provided and was observed by this auditor. The facility does not conduct forensic medical examinations of victims. SAFE / SANE protocols are performed at a community hospital in Newark. The two contractors have been trained in both the basic PREA requirements as well as the four additional components identified in part (a) of this standard. Kintock Policy 3.05, pg. 7 supports compliance. Staff interviews support compliance. The facility meets this standard.

**Standard 115.241 Screening for risk of victimization and abusiveness**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 7 provides language that supports compliance with all components of this standard. The pre-audit survey indicates that 100% of residents entering the facility whose length of stay is in excess of 72 hours are screened for risk of victimization or abusiveness. The facility has a system in place that provides for a 30 day re-assessment of all residents, inclusive of record and file checks, a determination as to whether the resident desires further counseling, and whether there are any staff, contractors, or volunteers that make the resident not feel safe. A final determination is made as to whether re-classification is in order. All provisions identified in part (d) and (e) relative to assessing risk are part of the screening tool. Policy further provides for reassessment of risk level when warranted. Prohibitions on discipline for residents' refusal to answer (or not disclosing complete information) are consistent with part (h). Physical and procedural integrity of the information collected during the assessment process is good. Staff interviews, resident interviews, and a random file review reflect a solid system that exceeds this standard.

**Standard 115.242 Use of screening information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 8 - 9 provides language that satisfy all components of this standard. Information obtained via the risk screening process is captured on an automated (excel) report format. Information is limited to a need to know basis. Housing and program decisions are based on a review of the restricted excel document. Secondary documentation reviewed by this auditor as well as staff and resident interviews serve to support compliance. Determinations are individualized. Policy (3.05) further provides for consideration of transgender and intersex residents in that their own views be considered, that their screening be done case by case, and that they be allowed to shower separately. The facility reported that no transgender on intersex residents were assigned to the facility at the time of audit. There are no special housing units or areas utilized for placement of special populations as identified in part (f) of the standard. The facility meets this standard.

**Standard 115.251 Resident reporting**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Facility Standard Operating Procedure (SOP) 26 pg. 3 as well as Kintock policy 3.05, pg. 9 serve to provide language supportive of this standard. The facility does offer multiple internal ways for residents to privately report sexual abuse or harassment. Signage, the resident handbook, handouts, and training materials all support good communication of these methods and related contact information. Residents have the option of remaining anonymous and may contact (via phone) SAVE of Family Service League, Inc. or the office of the New Jersey DOC Ombudsmen. SAVE is able to receive and immediately forward resident reports of sexual abuse or harassment to the facility while allowing the resident to remain anonymous. The Ombudsmen reports concerns to the NJDOC for appropriate handling. Policy (3.05) further provides that staff will accept verbal, written, anonymous, and third party reports consistent with part (c) of the standard. The facility staff training component advises staff on how they can report privately when sexual abuse or harassment of residents is suspected. Random staff and resident interviews reflect compliance. The facility has developed an exceptional system for resident reporting and is rated accordingly.

**Standard 115.252 Exhaustion of administrative remedies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 9 - 10 provides language consistent with all elements of this standard, with one exception. The facility treats any assault or harassment allegation as an emergency and reduces the administrative response time frame to 48 hours, which exceeds the PREA Standard. The PREA grievance process is communicated to residents via the resident handbook. The facility reports no PREA related grievances in the past reporting period. The facility has a good system in place to address administrative remedies if and when PREA grievances are received. The facility meets this standard.

**Standard 115.253 Resident access to outside confidential support services**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 10 contains language that support all components of this standard. The facility has entered in to a memorandum of understanding with SAVE of Family Service League, Inc. which will provide victim advocacy services as required by part (a) of this standard. Contact information is posted on signage within the facility and near the resident telephones. This auditor did contact the provided number for SAVE and was able to connect with an appropriate contact via a resident dedicated phone. Phone calls are not monitored. Additionally, contact information is provided as part of initial resident training via power point presentation and handouts. The facility substantially exceeds requirements of this standard.

**Standard 115.254 Third-party reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 10 provides that third party reports of sexual abuse and sexual harassment may be received through the company website. The Kintock Group website does provide its policy as well as a mechanism to report abuse and harassment as specified in this standard. There have been no third party reports this past reporting period. The facility meets this standard.

**Standard 115.261 Staff and agency reporting duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 10 - 11 provides language that supports all elements of this standard. Staff interviews reflect compliance. There has been one resident allegation of staff sexual misconduct this past reporting period. The allegation was properly referred by the facility to the contracting authority (NJDOC) for appropriate handling. The facility meets this standard.

**Standard 115.262 Agency protection duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 3.05, pg. 11 requires that once the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, they (the facility) shall take immediate action to protect the resident by separating the victim from perpetrator and attending to the needs of the victim while not impeding in the investigation. There have been no such occurrences this past reporting period. The facility meets this standard.

**Standard 115.263 Reporting to other confinement facilities**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 11 requires that upon receipt of an allegation that a resident was sexually abused while confined at another facility, the head of the facility is to notify the head of the reporting facility or appropriate office of the agency where the alleged abuse occurred. This notification is to be reported within time frames specified by the standard. All claims of sexual assault will be immediately reported to the appropriate investigative authority. The facility reports no such occurrences this past twelve months. The facility meets this standard.

**Standard 115.264 Staff first responder duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05 part 264 contains language that satisfies all elements of the standard. The training curriculum and power point presentation for staff who may be first responders contains (minimally) the training topics identified in part (a) of this standard. Staff interviews demonstrate an effective staff training program. There have been no first response situations this past reporting period. The facility meets this standard.

**Standard 115.265 Coordinated response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard Operating Procedure (SOP) 26 serves as the facility emergency plan in coordinating a response to an incident of sexual abuse. The plan is inclusive of command, first responders, medical - mental health response, and the investigation phase. The plan has been localized for facility use. The facility meets this standard.

**Standard 115.266 Preservation of ability to protect residents from contact with abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Resident Supervisors (security staff) are represented by the American Federation of State and Municipal Employees (AFSCME). Facility policy 3.05 mandates language as specified by this standard to guide future contracts. The facility has not entered in to a new agreement since August 20, 2012. This is the facilities first audit. The facility meets the standard.

**Standard 115.267 Agency protection against retaliation**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 12 contains facility protocol that assure protection of residents and staff who report sexual abuse or harassment or cooperate with such investigations. Language is consistent with the requirements of the standard. The facility has designated staff to implement the plan should it be needed. The plan has not been exercised this past reporting period. There has been one resident who made an allegation of staff sexual misconduct. The investigating authority (NJDOC - SID) moved the resident to a NJDOC facility within 24 hours of the allegation for separation and investigative purposes. The facility does have a plan in place that satisfies the standard, and is rated accordingly.

**Standard 115.271 Criminal and administrative agency investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct administrative or criminal investigations in to sexual abuse or sexual harassment of residents. Allegations are reported to the investigative divisions of the contracting authorities (NJDOC - SID or NJ Parole Authority). Facility policy 3.05 does contain protocol that calls for staff to cooperate with outside investigators and to remain informed about the progress of the investigation. The facility meets this standard.

**Standard 115.272 Evidentiary standard for administrative investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct administrative or criminal investigations. This standard is not applicable to the facility.

**Standard 115.273 Reporting to residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 13 contains reporting protocols that satisfy all elements of this standard. There has been one allegation of staff misconduct this past year. The investigating authority (NJDOC - SID) moved the resident to a NJDOC facility within 24 hours of the allegation for separation and investigative purposes. The plan was consequently not exercised as the resident was no longer in the facilities custody (and was not in there custody at the time of audit). The facility does have a plan in place that satisfies the standard. The facility meets this standard.

**Standard 115.276 Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 13 and Kintock HR Policy pg. 141 - 142 provide policy and procedure that satisfy all elements of this standard relative to disciplinary sanctions for staff. Kintock policy (per HR Policy part 63.13) is to terminate employees who are found in violation of improper conduct as identified in PREA standard 115.217. Reporting protocols are determined by New Jersey State law and are consistent with the requirements of this standard. There have been no disciplinary sanctions this past reporting period. The facility meets this standard.

**Standard 115.277 Corrective action for contractors and volunteers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 13 - 14 provides language that support compliance with this standard. Targeted staff interviews further supports compliance with regard to corrective action for contractors and volunteers. There have been no reported cases of volunteers or contractors engaging in sexual abuse or harassment this past reporting period, therefore there is no secondary documentation. The facility meets this standard.

**Standard 115.278 Disciplinary sanctions for residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 14 stipulates that any resident found to have committed substantiated sexual harassment or a sexually abusive act shall no longer meet the facilities community correction criteria and shall be discharged from the program and remanded to Parole or DOC. Further formal disciplinary actions will be sanctioned by the custodial law enforcement entity. As the facility does not administer discipline to residents for resident on resident sexual abuse, this standard is not applicable.

**Standard 115.282 Access to emergency medical and mental health services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 14 provides resident victims of sexual abuse with timely and unimpeded access to emergency medical treatment and crisis intervention services. The facilities standard operating procedures (SOP # 26) stipulates that in the event of a sexual assault, the contracting agency will be contacted immediately. If medical attention is necessary, residents will be escorted to either Northern State Prison (NJDOC) or Beth Israel Hospital Newark or UMDNJ Newark (NJSPB) unless otherwise instructed. Where appropriate, Sexual Assault & Violence Prevention & Education Center (SAVE of Essex County) will be contacted for assistance at the medical center. NJDOC Policy MED.MLI.OO7 identifies Beth Israel Hospital as the required medical facility for NJDOC facilities to use for treating victims of sexual assault. The facility does provide SANE trained medical staff and protocols. The facility meets this standard.

**Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 14 addresses all provisions of this standard. Targeted staff and contractual employee interviews serves to support compliance. Services will be offered without financial cost to the victim and in a manner consistent with requirements of this standard. There have been no incidents reported this past year that necessitated ongoing medical or mental health services. The system is in place should such treatment be necessary. The facility meets this standard.

**Standard 115.286 Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 15 provides procedure for post sexual abuse incident reviews. During the pre-audit this auditor did question whether one reported allegation rose to the level of necessitating a sexual abuse incident review. The allegation was made in January of this year and an administrative investigation by NJDOC - SID found the claim to be unsubstantiated. It was thought at the time that the allegation did not rise to the level of sexual abuse and consequently the facility did not conduct a post incident review. This auditor tends to agree with that decision after reviewing the allegation. However, as the determination was "unsubstantiated" rather than "unfounded", and given the broad definition of sexual abuse, this auditor recommended a review be conducted, albeit belatedly. The review was conducted on September 22nd and the content of the review was consistent with the requirements of this standard. The facility meets this standard.

**Standard 115.287 Data collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 15 - 16 provides guidance consistent with all elements of this standard. A standard reporting incident with definitions is utilized to gather facility specific information, which is relayed to the corporate PREA Coordinator. The information is aggregated for inclusion in to a corporate annual report. Data relied on is inclusive of all available incident based documents. The facility meets this standard.

**Standard 115.288 Data review for corrective action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 16 provides language consistent with the requirements of this standard. There has been one corporate "annual" report reflective of the previous reporting period statistics and data on sexual abuse and sexual harassment. Targeted staff interviews reflect intentions consistent with this standard and with corporate policy to make comparisons of information in the next annual report with the previous report in an effort towards quality improvement of the agencies efforts to better prevent, detect, and respond to incidents of sexual abuse and sexual harassment. The facility meets this standard.

**Standard 115.289 Data storage, publication, and destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3.05, pg. 16 addresses data publication, retention, and destruction. All time frames and integrity guards are in place to satisfy the standard. The facility has published a report on its web site utilizing aggregate data. Personal identifiers are removed in a manner consistent with this standard. The facility meets this standard.

**AUDITOR CERTIFICATION**

I certify that:

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

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

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

 Richard McVicar \_ October 20, 2015

Auditor Signature Date