PREA Facility Audit Report: Final

Name of Facility: Camp Florence Youth Transitional Facility
Facility Type: Juvenile
Date Interim Report Submitted: 07/22/2021
Date Final Report Submitted: 02/14/2022

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: D. Will Weir	**Date of Signature:** 02/14/2022

AUDITOR INFORMATION	
Auditor name:	Weir, Will
Email:	prea.america@gmail.com
Start Date of On-Site Audit:	06/10/2021
End Date of On-Site Audit:	06/10/2021

FACILITY INFORMATION	
Facility name:	Camp Florence Youth Transitional Facility
Facility physical address:	4859 S Jetty Rd, Florence, Oregon - 97439
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	Lynn Oliver
Email Address:	lynn.oliver@state.or.us
Telephone Number:	9717015847

Superintendent/Director/Administrator	
Name:	Pete Roberts
Email Address:	pete.roberts@oya.state.or.us
Telephone Number:	541-997-2076

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Characteristics	
Designed facility capacity:	25
Current population of facility:	15
Average daily population for the past 12 months:	16
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	17-24
Facility security levels/resident custody levels:	Close custody
Number of staff currently employed at the facility who may have contact with residents:	20
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Oregon Youth Authority
Governing authority or parent agency (if applicable):	
Physical Address:	530 Center St, Suite 500, Salem, Oregon - 97301
Mailing Address:	
Telephone number:	9717015847

Agency Chief Executive Officer Information:	
Name:	Joe O'Leary
Email Address:	joe.oleary@oya.oregon.gov
Telephone Number:	503-373-7212

Agency-Wide PREA Coordinator Information			
Name:	Lynn Oliver	**Email Address:**	lynn.oliver@oya.state.or.us

SUMMARY OF AUDIT FINDINGS	
The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met. Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.	
Number of standards exceeded:	
0	
Number of standards met:	
38	
Number of standards not met:	
0	
Not audited at the facility level: Audited at the agency-level, and not relevant to the facility-level audit because the facility has no independent responsibility for the operation of these standards.	5

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2021-06-10
2. End date of the onsite portion of the audit:	2021-06-10

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	◉ Yes ○ No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Sexual Assault Support Services and PeaceHealth Harbor Medical Center.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	25
15. Average daily population for the past 12 months:	15
16. Number of inmate/resident/detainee housing units:	1
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	○ Yes ○ No ◉ Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit

Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit

36. Enter the total number of inmates/residents/detainees in the facility as of the first day of onsite portion of the audit:	14
38. Enter the total number of inmates/residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	0
40. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0

41. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
43. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	1
44. Enter the total number of inmates/residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	1
47. Enter the total number of inmates/residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	The facility and agency did not have a reliable or functioning Screening for Risk of Sexual Victimization and Abusiveness in place as required by § 115.341. At a minimum, agencies are required to attempt to ascertain information about: "(1) Prior sexual victimization or abusiveness; (2) 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; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents."
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	20
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The following interviews of staff were conducted: Agency Head Designee, Agency Facilities Manager, Agency PREA Coordinator, Superintendent, Agency Human Resources, Investigator, PREA Compliance Manager, Higher-Level Staff for Unannounced Rounds, Mental Health, Contractor, Staff who perform Screening and Intake, Staff who monitor for Retaliation, and the Incident Review Team. An additional five staff were interviewed, representing various stations, shifts, and both genders. Due to the limited number of staff, there were not a sufficient number of additional staff to reach the goal of twelve. A total of 14 unique interviews were completed. Five were random, and nine were specialized.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	7
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	There is only one housing unit. 4 residents were aged 18 and 4 were aged 19. The remaining residents were aged 20 through 24. A racial minority declined to be interviewed.
56. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	◉ Yes ○ No

57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	PREA America was contracted to audit the Oregon Youth Authority facilities on January 27th, 2020. The Pre-Audit Phase, a desk audit of the facility/agency was initiated shortly thereafter. This included discussions and attempts to collect information regarding residents with risk factors. Several emails and phone calls were exchanged to clarify issues. This phase of the Audit was used to attempt to collaborate with the facility staff on questions and concerns with documenting compliance. The communication with the facility staff was used not only to comprehend the policies and procedures unique to the facility, but also to understand how PREA was put into practice. In February 2020, the agency provided a flash drive with agency policies. Background checks (child abuse registry) were randomly selected of staff, contractors, and volunteers to verify the initial background check, as well as the 5-year recheck requirement, but were not provided. Resident files were randomly selected to verify PREA education and PREA Screenings but were not provided. The Covid-19 pandemic forced the postponement of the Audit, and Pre-Audit work continued. On March 12th, 2020, issues with the agency screening tool (known as the Sexual Vulnerability and Aggressiveness Screening or SVAT) were raised. On April 27th, 2020, issues with the SVAT were identified. A collaborative decision was made to start using the Online Audit System (OAS) for the Audits. A kick-off call with all the facilities and the PREA Coordinator took place on May 3rd, 2021. Logistics and requirements for the On-Site Audits were discussed, including the need for staff lists (with assigned specialized staff identified), as well as youth rosters for random and targeted interviews. An explanation was provided of the "targeted" interview requirement and the need for a list of residents to cover the specific categories. A follow-up email was sent to make sure the lists and the categories were clear, as discussed on the call.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	3
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
61. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
62. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
63. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
64. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
65. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
66. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
67. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	See the answer to question 57 above. Despite numerous requests, neither the facility nor the agency provided information helpful in selecting targeted interviews.
68. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	1
69. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The facility does not use isolation.

70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	PREA America was contracted to audit the Oregon Youth Authority facilities on January 27th, 2020. The Pre-Audit Phase, a desk audit of the facility/agency was initiated shortly thereafter. This included discussions and attempts to collect information regarding residents with risk factors. Several emails and phone calls were exchanged to clarify issues. This phase of the Audit was used to attempt to collaborate with the facility staff on questions and concerns with documenting compliance. The communication with the facility staff was used not only to comprehend the policies and procedures unique to the facility, but also to understand how PREA was put into practice. In February 2020, the agency provided a flash drive with agency policies. Background checks (via the child abuse registry) were randomly selected of staff, contractors, and volunteers to verify the initial background check, as well as the 5-year recheck requirement, but they were not provided. Resident files were randomly selected to verify PREA education and PREA Screenings, but they were not provided. The Covid-19 pandemic forced the postponement of the Audit, and Pre-Audit work continued. On March 12th, 2020, issues with the agency screening tool (known as the Sexual Vulnerability and Aggressiveness Screening or SVAT) were raised. On April 27th, 2020, issues with the SVAT were identified. A collaborative decision was made to start using the Online Audit System (OAS) for the audits. A kick-off call with all the facilities and the PREA Coordinator took place on May 3rd, 2021. Logistics and requirements for the On-Site Audits were discussed, including the need for staff lists (with assigned specialized staff identified), as well as youth rosters for random and targeted interviews. An explanation was provided of the "targeted" interview requirement and the need for a list of residents to cover the specific categories. A follow-up email was sent to make sure the lists and the categories were clear, as discussed on the call. The On-Site Audit was held on June 10th, 2021, starting with a briefing that confirmed the current population, reviewed the agenda and logistics, discussed mandatory reporting, and clarified the need to allow any staff or resident who requests an interview to get one. The requested list of youth with identified vulnerabilities was not provided. Although attempts were made to select interviews in accordance with the guidance of the PREA Auditor Handbook to random selections of residents to ensure diversity and those with risk factors, this was impossible at this facility, since staff offered no notion of any youth with a risk factor. The Auditor thought of interviewing younger residents, but all residents were adults 18 to 24 years of age. 8 of the 14 residents at the facility were aged 18 and 19, putting the youngest residents in the majority, and thereby making the issue of age (by itself) less of a risk factor. However, the pool of 10 that were selected randomly for interviews did contain residents with risk factors. Residents self-identified during interviews as being LGBTI and as having survived sexual abuse and other forms of violence.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	5

72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☐ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	All available staff were interviewed.
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No
a. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☑ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The following interviews of staff were conducted: Agency Head Designee, Agency Facilities Manager, Agency PREA Coordinator, Superintendent, Agency Human Resources, Investigator, PREA Compliance Manager, Higher-Level Staff for Unannounced Rounds, Mental Health, Staff who perform Screening and Intake, Staff who monitor for Retaliation, and the Incident Review Team. An additional five staff were interviewed, representing various stations, shifts, and both genders. Due to the limited number of staff, there was not a sufficient number of additional staff to reach the goal of twelve. A total of 14 unique interviews were completed. Five were random, and nine were specialized.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	9
76. Were you able to interview the Agency Head?	◉ Yes ○ No

77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No
78. Were you able to interview the PREA Coordinator?	◉ Yes ○ No
79. Were you able to interview the PREA Compliance Manager?	◉ Yes ○ No ○ NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☑ Medical staff ☑ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff ☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	○ Yes ◉ No
a. Enter the total number of CONTRACTORS who were interviewed:	0

b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The following interviews of staff were conducted: Agency Head Designee, Agency Facilities Manager, Agency PREA Coordinator, Superintendent, Agency Human Resources, Investigator, PREA Compliance Manager, Higher-Level Staff for Unannounced Rounds, Mental Health, Staff who perform Screening and Intake, Staff who monitor for Retaliation, and the Incident Review Team. An additional five staff were interviewed, representing various stations, shifts, and both genders. Due to the limited number of staff, there was not a sufficient number of additional staff to reach the goal of twelve. A total of 14 unique interviews were completed. Five were random, and nine were specialized.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.

84. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
85. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	◉ Yes ○ No
86. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	◉ Yes ○ No
87. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	◉ Yes ○ No
88. Informal conversations with staff during the site review (encouraged, not required)?	◉ Yes ○ No

89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	The Site Review included obtaining and studying the facility diagram of the physical plant, observing staff and residents, and their supervision and movement, along with casual conversation to ascertain whether observations made were of "normal" supervision and movement. Random checks were made to assure doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance with cross-gender supervision guidelines. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are at high risk for sexual abuse. PREA Postings, including third-party reporting postings, in the Visitation area, were checked. Confirmation of the availability to the staff of First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were assessed.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	◉ Yes ○ No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	Proof of practice documentation was not adequately provided during the Pre-Audit Process. Although this was quickly rectified after the Interim Report was issued, there were few opportunities to oversample documentation, due to the volume of documentation being provided at that time regarding 6 OYA facilities. The COVID-19 pandemic had caused Audits to be postponed to the point that two years' worth of Audits needed to be completed.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	5
99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ◉ No ○ NA (NA if you were unable to review any sexual abuse investigation files)

Inmate-on-inmate sexual abuse investigation files

100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	5

101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	5
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ◉ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	5

109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	Investigative files included those from other facilities, since investigations are completed by agency investigators, and none was available from Camp Florence.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	◉ Yes ○ No

a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	○ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ◉ Other
Identify the entity by name:	PREA America, LLC. I own the company.

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
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.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and it has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment, and it includes sanctions for those found to have participated in prohibited behaviors. Although written policy had been provided during the Pre-Audit Phase of the Audit, there was a lack of proof of practice to indicate the policy and/or the PREA Standards were being followed as required by PREA. Corrective Actions: The Director of the Oregon Youth Authority (OYA) initiated top-level changes that mandated PREA compliance and have remained constant throughout the Corrective Action period. These changes included the immediate assignment of staff sufficient to coordinate PREA and direct accountability to the agency's second in command, as well as the development and implementation of a Corrective Action Plan (CAP) adequate to bring the agency and CFYTF into compliance. On 11-28-21, the Director had a second video conference with the Audit Team, including the Deputy Director that is over PREA compliance, to verify that the agency is on track toward full compliance, and that the new PREA accountability process that goes through the Deputy Director will be permanent. Early in the CAP, memos went out directing enough time and authority for PCMs to assure PREA compliance in their facilities. Also, training was developed and provided for PCM and SAARC duties. The final piece was to see that changes had become effective and sustainable. This included "active supervision and accountability that is documented" and ongoing "problem recognition regarding systemic breakdowns." Of particular importance was sustaining the change that assured that "The PREA Coordinator must not be supervised by anyone, such as the Chief Investigator, whose work product must be reviewed by the PREA Coordinator for compliance." Analysis: Evidence reviewed regarding this Standard includes the agency organizational chart, interviews with agency and facility officials, On-Site Reviews in 6 facilities, and PREA policies. The documents reviewed that provided proof of compliance and verification of practice included: Camp Florence PCM Duties - Authority and Time, with PCM's recent commitment; Notification of PREA Coordinator process; Zero tolerance for sexual abuse and harassment, including issues relating to LGBTQ+ youth; Employee training - Camp Florence refresher training 10-2021; Policy I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Policy CFYTF-II-A-10.0 Sexual Abuse Response Plan; and OYA Management Structure with PCMs. Important to OYA's sustainable return to full PREA compliance are reliable and effective processes for accountability. This includes HR investigations and employee evaluations of employees officially tasked with PREA responsibilities. Although these processes function on their own timelines, the Auditor was fortunate to be able to verify from top OYA officials, prior to the end of the Corrective Action Period, that these processes are active in the agency and are addressing issues raised during the Audit. These verifications provide at least a triangulation of evidence of compliance with this Standard.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that if a public agency contracts for the confinement of its residents, it shall require the contractor to adopt and comply with the PREA Standards and monitor the contractor to ensure that the contractor is complying with the PREA Standards. The Interim Report stated, “The agency has not provided enough information to overcome the contradictory information and confusing information that has been received. For example, residents believe OYA has contractual facilities. The PC states that OYA utilizes facilities for youth that are on probation and parole. Additional information would help determine whether these facilities are required to be PREA compliant.” Corrective Action: The CAP required research to determine which programs are designated for 50% or more for OYA youth, whether contracts mention PREA compliance (If yes, provide them to the Auditor), and to coordinate next steps, as appropriate. Upon completing their internal research, the agency states that “The Oregon Youth Authority (OYA) does not contract with other entities for the confinement of youth committed to OYA. Youth who reside outside of a secure facility (youth correctional facility or transition facility) may be placed in substitute care, which includes foster homes and Behavior Rehabilitation Services (BRS) residential programs.” OYA does not contract for the confinement of its residents, but even under these circumstances it may be that a facility would fall under the Prison Rape Elimination Act (PREA) as systemic, contractual, definitional, or population changes occur. PREA Coordinators must be aware of all the places where OYA youth are housed, as well as the latest guidance from the U. S. Department of Justice regarding the applicability of this Standard. Analysis: The biggest lesson learned from this process relates to Standard 115.311, because of the importance of having an engaged PREA Coordinator who will get and understand facts, and then assure PREA compliance. In addition to interviews with OYA PREA administrators, the Auditor reviewed a contract for behavior rehabilitation services and reviewed emails with information from contract, procurement, and community resource officials detailing their research. The contract was for behavioral health care that youth on probation or parole may qualify for based on a treatment need, not a criminal offense. These considerations indicate compliance with this Standard at this time, but they need to be reconsidered during each PREA Audit.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	CFYTF develops, documents, and makes its best efforts to comply with a staffing plan that provides adequate staffing levels and video monitoring to protect residents against abuse. In calculating adequate staffing levels, and in determining the need for video monitoring, CFYTF takes into consideration: Generally accepted juvenile detention and residential practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; The composition of the resident population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or Standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and Any other relevant factors. At least once annually, CFYTF, in collaboration with the PREA Coordinator, is required to review the staffing plan to see whether adjustments are needed to: the staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan, to ensure compliance with it. The Interim Report stated, “An unsigned Staffing Plan created in February of 2020 was provided in OAS. Even if this plan was signed and implemented, the annual review is past due. Additionally, the PC stipulates that protocols are not in place to document any deviations to the staffing plan.” Corrective Action: The CAP required that the Staffing Plan be updated, reviewed, and approved by the Superintendent. Additionally, the key word “staffing plan deviation” was added to the JJIS Unit Log. A requirement for documentation was added to the protocol. Screen shots of documented staffing plan deviations were provided as proof of practice. Analysis: In addition to the interviews conducted during the On-Site Audit (with the Superintendent, the PREA Coordinator, and high-level staff), and the observations made during the Site Review, additional documentation was provided to verify full compliance. Documentation was provided in documents such as II-A-3.0 Interactive Supervision of Youth; training regarding agency-wide policy and procedural changes regarding resident showers; Walkthroughs; I-A-3.0 Interactive Supervision (Pg. 4, B); Staffing Plan; and Staffing Plan Update and Review (with associated documents including staffing deviations).

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	No cross-gender searches are permitted by OYA or Camp Florence, absent exigent circumstances, which must be documented. Residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, other than in exigent circumstances, or when such viewing is incidental to routine cell checks. Staff of the opposite gender announce their presence when entering a resident housing unit. Staff are forbidden from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, such may be determined amid conversations with the resident, through review of medical records, or, if necessary, by obtaining that information as part of a broader medical examination conducted in private by a medical practitioner. TYCF has trained staff in conducting cross-gender pat-down searches in exigent circumstances, and in conducting searches of transgender and intersex residents, in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs. Analysis: Documentation to prove compliance with this Standard was contained in sets of documentation and proofs of practice under these headings: Policy II-A-2.0 Searches of Youth and Youth Property in OYA Facilities; Search Policy Attachments A-C; Policy I-A-10.1 Meeting LGBTQI Youth Needs; Policy II-A-2.0 Searches of Youth (Pg. 7, B. 2, A); Policy IIA- 3.0 Interactive Supervision (Pg. 4, D); Policy II-A-3.0 Interactive Supervision (Pg. 4, C); Policy II-A-2.0 Searches of Youth (Pg. 8, E); and 2470 LP - Contraband and Searches for Facilities (training). PAQ documentation provided, including policies and information about training, is consistent with interviews conducted with residents and staff. 100% of those interviewed answered interview questions in a way that indicates that facility practices are compliant with this Standard. The practice of opposite-gender staff announcing their presence when entering a resident housing unit was observed by the Audit Team during the Site Review. This culminates in a triangulation of evidence demonstrating compliance with this Standard.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that the agency take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. OYA policies address the identification of needs, and the provision of appropriate services, during intake and throughout the time the resident is in care. OYA has policies to provide residents with disabilities and residents with limited English proficiency with 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. Policy prohibits the use of resident interpreters, resident readers, or other types of resident assistants, other than 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 ß 115.364, or the investigation of the resident's allegations. In the 12 months reviewed for this Audit, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used, and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of First-Response duties under ß 115.364, or the investigation of the resident's allegations. During the Pre-Audit Process, the agency stipulated that it was not adequately screening for disabilities as per Standard 341, and no examples or proof of practice were provided agencywide for Standard 316. Additionally, the contract with interpreters expired. Corrective Action: During the CAP, a new contract (or extension) with interpreters was secured, and staff received updated training on how to access the services available to them through the contract. The other issues to address had been identified prior to the PAQ and related to the need for a reliable system for the identification and tracking of residents with disabilities, as also addressed in concert with other Standards. OYA researched its prior efforts to develop this tool and collaborated with Just Detention International to develop its new tool for vulnerability and aggression assessment. The tool was reviewed, approved, and implemented. Staff were trained, and all residents were screened with the new tool. Analysis: Documents reviewed include Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 8, D. 5); Policy I-D-2.1 Use of Language Services; Policy II-E-2.4 English Plus – Facility; Interpreter Services Local Operating Procedure (LOP); IRCO (Oral Interpretation) 11757 comprehensive file (a-d); Hearing Impaired Interpreter Requests; Intake Close Custody Youth Safety Orientation YA 4033 – 2019; Youth Safety Guide 2020; Interpreter Contract – Signed; and Language interpreter protocol and purchase order. Also provided was proof that the staff have recently been trained regarding how to access interpreter services. The On-Site Review, interviews conducted (including both residents and staff), and the documents provided to satisfy the CAP, are a triangulation of evidence that the facility is compliant with the provisions of this Standard.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA policy prohibits hiring or promoting anyone who may have contact with residents, and it prohibits enlisting the 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 USC 1997); 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; or Has been civilly or administratively adjudicated to have engaged in the activity described. Policy requires the consideration of 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. Policy requires that, before it hires any new employees who may have contact with residents, OYA conducts criminal background record checks; consults the Child Abuse Registry; and, consistent with Federal, State, and local law, makes 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. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The agency provides 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. However, acceptable proof of practice of background and child registry checks were not provided during the Pre-Audit process as required. Corrective Action: The protocol that was developed during the CAP includes documented collaboration between DHS and OHA for retrieving background information for OYA staff, and between the school system and contracting entities for others. A longstanding and reliable system of conducting criminal background checks was identified within OYA, but it needed to be strengthened through the maintenance (and sharing) of documentation that the background checks had been completed, while continuing to protect information from inappropriate disclosure. Analysis: Interviews conducted with HR and OYA administrators were considered in compliance determinations. Although there was some confusion prior to the On-Site Review, during the CAP no information was received that was not consistent with full PREA compliance. Documents reviewed included Policy I-A-10.0 Preventing Youth Sexual Abuse (Pgs. 5 & 6, B & Pg. 6, B); Hiring and Promotions Protocol; and randomly selected proof of contractor, school, and employee criminal record and child abuse registry checks. These sources of information provide a triangulation of evidence that OYA is compliant with the Standard.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Camp Florence has made a substantial modification to its existing infrastructure and video monitoring system since the last PREA audit. Analysis: Evidence used to determine compliance with this Standard includes the interview with the Agency Head designee and Superintendent and documentation of the agency's plans regarding the design, renovation, modification, and expansion of their facilities. Hundreds of pages were provided for facilities agency-wide, including the feasibility study, meeting agendas and minutes, design phasing and schedules, architecture designs, schematics, progress reports (narratives and blueprint-style descriptions), camera layouts and descriptions, and 5D reports, all with emphasis on safety, security, supervision and/or risk information. These documents, taken in context with the information from interviews and the Site Review, provide verification of compliance.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	For agencies such as OYA, which conducts its own administrative investigations of allegations of sexual abuse, this Standard requires the agency to "follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." The Standard includes specific rules regarding how this is to be done, and how to care for alleged survivors of abuse. For example, it requires the agency to, "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. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs." In addition, it requires the agency to "attempt to make available to the victim a victim advocate from a rape crisis center." The Standard recognizes that these services are not always available in every locality, and it provides provisions that take into account various circumstances. For example, it states that, "If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers." The requirement for victim advocates goes far beyond including them in forensic exams. The Standard states, "As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals." In addition to what is required in this Standard, Standard 115.353 requires that all residents have a level of access to advocates. Standard 115.353 states that facilities shall provide residents "access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations . . . ." Since no complete investigative files had been provided (even agency-wide), at the time of the Interim Report, it had not been shown whether they follow this Standard in practice. They do have an MOU with the State Police that includes PREA. Also, there is an MOU with Sexual Assault Support Services. Corrective Action: The facility safety response plan was reviewed and enhanced during the CAP, and protocols were established to assure that, at least annually, specific information regarding providers will be checked for accuracy. The Health Services Sexual Assault Response Procedure was incorporated. All related forms and policies were reviewed to get rid of any inconsistencies or confusing wording. Analysis: Documentation provided and reviewed includes the following: PAQ; Policy I-D-4.0 Professional Standards Office Investigations; Oregon State Police (OSP) PREA Agreement; Facility SARRT Sexual Abuse Incident Checklist; Facility First Responders to Sexual Abuse Checklist; Policy II-A-1.2 Preserving Chain of Evidence; Policy I-A-10.0 Preventing Youth Sexual Abuse; QHMP minimum qualifications; Sample documentation for Mental Health Follow-up; Residence access to outside support - Advocate MOU; Advocate and SANE Annual Check for CFYTF (to assure the information is current and accurate); Advocacy Flyers – Sexual Assault Support Services; Notification to PREA Coordinator process; Access to outside support services; Third-party reporting sample; Resident access to legal representation (documented examples of calls made); Forensic medical exam verification; and Victim advocate information verification. An example was provided to show proof of practice. Digital photos were provided to show the current information that is posted for staff and residents. At the end of the CAP, information from primary sources was consistent with other sources, as well as with compliance with the Standard.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard is clear and direct in its requirement that, “The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.” The Standard further requires that agencies have a policy that ensures compliance, and that the policy be published. Agencies must provide their records in order to demonstrate compliance. Corrective Action: The Audit Team initiated video conferences, discussions, and email exchanges with agency officials regarding concerns expressed by residents in several OYA facilities. OYA administrators initiated an agency-wide response to the concerns about bullying and the risk of sexual harassment. Apart from those issues, the initial focus of the CAP was for the Audit Team to get access to all the allegations and investigations of sexual abuse and sexual harassment for a review. Once the investigations were reviewed, concerns were addressed in other Standards associated with investigations, such as Standard 371. Additional training to assure that staff know to report all allegations was covered in Standard 331. Additional responses by the agency/facility, to act on information learned during investigations, were covered in the follow-ups to Incident Reviews required in Standard 386. Analysis: Evidence used to determine compliance with this Standard includes interviews with the Agency Head designee and Investigative staff. Documentation reviewed includes allegations and investigations verifying compliance with this Standard in practice agency-wide, especially after questions were asked and answered by secure email. Additionally, policies were reviewed, including I-D-4.0 Professional Standards (Pgs. 6. A & 8, I). The pertinent policy is published at https://www.oregon.gov/oya/pso/Pages/prea.aspx. These documented efforts have culminated in a triangulation of evidence that the facility complies with this Standard.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA is required to train all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' rights to be free from sexual abuse and sexual harassment; residents' and employees' rights to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse; how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including LGBTI or gender-nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities and relevant laws regarding the applicable age of consent. During the Pre-Audit process, some policies and curricula were provided, but not adequate proof of practice. The Interim Report stated, "Most of these records indicate that no annual refreshers have been received in the past year. The annual refresher is a 12-minute video. This video is a broad overview of PREA and oversimplifies some of the topics, such as the First Responder Duties. Some staff interviews suggest in-person training would be preferred. They need specifics and an ability to ask questions. Some residents indicate that staff may benefit from training that includes better and consistent ways of dealing with rule violations. Two residents state a belief that a staff member is not responsive to rule violations related to cognitive disabilities. Three residents do not believe staff are appropriate or consistent when dealing with residents being bullied due to having prior sex offenses. The Superintendent verified parts of a story the auditor heard from residents about a former sex offender having to defend himself against bullying behavior. Residents told the auditor that the victim of the bullying got in trouble, but the bullying residents did not receive sanctions for the behavior that occurred in front of staff." The Interim Report also documented other concerns and immediate attempts by the Audit Team to address them, "After 1/3 of residents indicated regular use of the 'N' word and other types of bullying at the facility, the audit team had a video conference with high-level agency administrators (Agency Head Designee and Facilities Manager/Agency Deputy Director) who voiced an understanding that these things are inappropriate, against agency policy, and may lead to sexual harassment." This video conference proved to be a valuable step toward developing the CAP. Corrective Action: The CAP required that an acknowledgement of understanding be added to the agency's training software (Workday). Additionally, administrative oversight ensured that all new training is uploaded into Workday, and that employees complete all their required training in Workday. This occurred in a manner such that, when training was completed by employees who were behind on their training, the verification (including screenshots and electronic verification from Workday) provided to the Audit Team included verification of these CAP action items. In the meantime, OYA has launched a new training program to address concerns from the residents about bullying that bordered on harassment. Some of the in-depth aspects of this training are to be completed by June 2022, in collaboration with community agencies that are LGBTIQ+ resources. Core components of this training have already been provided to staff in a refresher training course, with multiple components covering multiple Standards. It covers how to respond to harassing behavior, the respectful treatment of LGBTIQ+ residents, and searches of transgender youth. Analysis: Evidence used to determine compliance with this Standard includes interviews with randomly selected staff, training policy, and staff training curricula. Training files (with acknowledgements of understanding) were provided regarding 5 randomly selected staff. Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 6, C); https://youtu.be/LTetpd2vdo4; Policy I-D-3.9 Staff Training and Development; Policy I-D-3.8 Agency Training Program; Training 3330 Syllabus - PREA Scenarios 2020; Training 3330 LP - PREA Scenarios 2020; Training 3330 HO PREA Scenarios - Worksheet and answers 2020; PREA Scenarios laminated cards; Training 1325 Syllabus - PREA Introduction; Training 1325 LP - PREA Introduction updated 2020; randomly selected staff records; and Master list of all staff trained. During the CAP, documentation was provided that staff who were behind on their training became current; and additional evidence was received, including: Policy I-A-10.1 Meeting LGBTQQI Youth Needs, with updates effective 10-2-21; Employee training - LGBTQ+ Awareness training plans; Employee Training - PREA Acknowledgement and Understanding; Employee training 2021; Zero tolerance for sexual abuse-harassment- LGBTQ+ youth discussion; training regarding agency-wide policy and procedural changes regarding resident showers; and Employee training - Refresher training 10-2021, showing that the remaining training requirements in the CAP were included. Curricula for this October training were provided, as well (including 3 videos), with employee signatures acknowledging understanding of the material, along with the outline of the remaining training components to be provided in June 2022. These documents, considered in context with what was learned during interviews, and the requirements of the CAP, indicate compliance with this Standard.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Volunteers and contractors who will have contact with residents are required to have been trained on their responsibilities, under OYA policies and procedures, regarding sexual abuse and sexual harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is to be based on the services they will provide, factoring in the level of contact they will have with residents. All contractors who will have contact with residents should have been notified of the agency and facility's zero-tolerance policy regarding sexual abuse and sexual harassment, as well as informed of how to report such incidents. The agency is to maintain documentation confirming that their contractors and volunteers understand the training they have received. During the Pre-Audit process, policies and blank training forms were provided, leaving proof of practice to be provided during the CAP. Corrective Action: Since the tracking of training for volunteers and contractors generally uses the same software as for employees, the details of the CAP for this Standard were the same as for Standard 331 but included teachers. For the past year, due to COVID-19, volunteers and contractors have not had access to the facility. Documentation regarding previous volunteers is provided. Analysis: In addition to documentation provided for Standard 331, to show full compliance the facility provided their Volunteer Training quiz, volunteer retraining email (with instructions), Volunteer Retraining Forms, Facility Access Level 2 Training for Volunteers and Interns, Facility Access Level 3 Training for Employees and Contracted Providers, Volunteer training acknowledgements; training link; and the Contractor (teacher) training 2021 transcript from Workday Learning System. This, considered with interviews conducted, provides a triangulation of evidence of compliance.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Residents are to receive information, at time of intake, about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Additionally, the Standard requires that, “Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.” The facility is required to provide education in formats accessible to all residents, including those who have limited English proficiency and/or are deaf, visually impaired, and/or otherwise disabled, as well as to residents who have limited reading skills. The agency is also to ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Policies and blank forms were provided during the Pre-Audit Phase of the Audit, but not proof of practice. Additionally, records were provided that indicated a lack of PREA Education. Interviews did not indicate a culture of zero-tolerance regarding verbal violence at the facility. Corrective Action: The CAP required that, in addition to demonstrating that all residents get PREA education, as required by the PREA Standard, the facility would address the acts of verbal violence that may constitute warning signs that more preventative work needs to be done regarding sexual abuse or sexual harassment. In the jointly developed CAP, the facility agreed to implement the changes. Documentation was to include proof that changes were approved at agency and facility administrative levels, proofs of training being received and understood by residents and staff, proofs of distribution of documents that inform residents and staff of the changes, proof that adequate follow-up is done that verifies that the changes have been institutionalized in the practices of staff and residents, and proof that no staff or resident is getting conflicting messages that undermine sustained compliance. Analysis: Evidence considered for compliance determination included interviews of residents and staff, along with the documentation provided. Documentation included the randomly selected youth education (YA 4033) documentation forms provided as part of the completion of the PAQ. Other documentation included Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 8, D); Hotline Contact Card; Intake Close Custody Youth Safety Orientation YA 4033 – 2019; Hotline Poster displayed in Facility; Link to Youth Sexual Safety video; Abuse Report form; Youth Sexual Safety Education YA 4034; and Youth Safety Guide 2020. Resident training materials were also provided in Spanish. The ability to utilize resources for other languages and for impairments was also verified. These sources provide a triangulation of evidence that the facility is compliant with the provisions of this Standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that “the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.” The training “shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.” Further, “The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.” During the Pre-Audit Process, policies were provided, but not proof of practice. Corrective Action: Compliance with the CAP was immediately undertaken by the agency. Investigators produced their NIC certificates, typically after retaking the training. Additionally, the CAP required the agency to “Evaluate the training needs of investigators. For example, if they are not experienced sexual abuse investigators, perhaps they should be assigned to assist an investigation before being assigned a case on their own. If they have never conducted any type of investigations, their training should include intermediate training. Sexual abuse training has prerequisites. (It is never a training for beginners.) Investigators should be experienced and trained for other types of investigations before moving on to sexual abuse investigations. If an investigator has been found not to follow the training received, remove them from the list of investigators until this is resolved. Someone supervising or reviewing the work of investigators must be familiar with the components of sexual abuse investigations in confinement, involving juveniles, and how they differ from other types of investigations.” Analysis: Interviews with investigative staff were conducted, and agency training policy for investigative staff was reviewed, and investigator training curricula. Prison Rape and Sex Assault Investigations; NIC Investigating Sexual Abuse in Confinement Setting; OYA Investigator & Interview Training with PREA Focus; Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 7. 3 B); agency-wide proof of training documentation for 5 Investigators; and recently completed investigations, indicate compliance with this Standard.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA has written policies related to the training of medical and mental health practitioners. The training includes: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Policies were provided during the Pre-Audit Process, but not proof of practice. The PAQ stated that none had been trained. Corrective Action: The CAP focused on the provision of training transcripts and certificates, but also verified the curriculum to make certain that the curriculum matched the training received. Analysis: Evidence used to determine compliance with this Standard includes a video interview with the Qualified Mental Health Professional (QMHP) temporarily assigned to the facility until someone new is hired. Youth with behavioral health needs were interviewed. Additionally, staff and administrators were interviewed regarding the mental health care provided at the facility. Documentation reviewed to determine compliance included Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 7, 3 C); PREA 201 for Medical and Mental Health Practitioners; and proof of completion of specialized training, as well as verification of completion of the PREA training that all staff are required to complete. These documents were consistent with information learned from interviews and the PAQ, verifying compliance with the Standard and completion of the CAP.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA has a policy consistent with this Standard that requires that, upon admission to the facility or transfer from another facility, all residents must receive screening, during their Intake, for risk of sexual abuse victimization and/or sexual abusiveness toward other residents. This information, collected as part of the screening process, is to be ascertained through conversations with the resident during the Intake process, medical and mental health screenings, and classification assessments, and by reviews of court records, case files, facility behavioral records, and other relevant documentation from the resident's files. During the Pre-Audit Process, policies and blank forms were provided, but not proof of practice. The PC stated that the screenings were not adequate to meet the requirements of this Standard. The Interim Report documented that "Interviews indicated that it was the practice to list on the public board who was going to programming for sex offenders. This was confirmed by the Camp Director . . . . A clarifying interview with the Agency Head Designee and Director of Facilities/Deputy Director of the Agency indicated that OYA expects staff to make efforts to maintain the confidentiality of the youth's risk factors, even if it can be obtained through other sources. It must be noted that policy also prohibits staff from displaying computer information to anyone that is unauthorized to view it, according to interviews. However, the residents at Camp Florence access the multipurpose room through the staff station. This makes the cameras viewable to the youth, along with any files, documents, or computer displays." Corrective Action: The issues to address had been identified prior to the PAQ and indicated need for a reliable system for identification and tracking of residents with possible risk factors. OYA researched its prior efforts to develop this tool and collaborated with Just Detention International to develop its new tool for vulnerability and aggression assessment. The tool was reviewed, approved, and implemented, along with appropriate updates in official protocols. Staff were trained, and all residents were screened with the new tool. Additionally, protocols were reinforced to protect and secure sensitive information. Analysis: Interviews were conducted with Risk Screening staff, with randomly selected residents, with the PREA Coordinator, and with the Compliance Manager. Documentation reviewed includes Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 12); Mental Status Interview Guideline; Sexual Violence Assessment Tool, and new tool; YCF Initial Health Screen; SVAT Checklist for facility; YCF Health History and Physical Assessment; YCF Initial Mental Status Assessment; and documentation of randomly selected residents being screened with the new tool. The documentation reviewed showed that the CAP had been followed, and that the concerns that had been brought up during Pre-Audit Process, and in the interviews with staff and residents, had been addressed.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA is required to use information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments, with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort, only 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. Isolation is not used at the facility. Lesbian, gay, bisexual, transgender, or intersex residents are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status. Lesbian, gay, bisexual, transgender, or intersex identification or status is not an indicator of likelihood of being sexually abusive. In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency considers, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Placement and programming assignments for each transgender or intersex resident are to be reassessed at least twice each year, to review any threats to safety experienced by the resident. Transgender and intersex residents are to be given the opportunity to shower separately from other residents. During the Pre-Audit process, policies were provided, but not proof of practice. Corrective Action: Corrective actions for this Standard related to Standard 341 above, as well as Standard 316, but also included a need to document that the information collected from residents is used to protect them. Analysis: Interviews were conducted with the PREA Coordinator and the Compliance Manager, Risk Screening Staff, and LGBTI residents. In addition to the information collected during the On-Site Review and in interviews, documentation reviewed includes the SVAT Checklist for the facility; Policy I-A-10.00 Preventing Youth Sexual Abuse (Pgs. 12 & 13); Policy I-A-10.1 Meeting LGBTQI Youth Needs (Pgs. 3, 4, 5), with updates, training, and protocols; and Policy II-B-1.2 Use of Time-out, Room Lock Other, Isolation, and Safety Programming. Camp Florence does not use Isolation, so no proof of practice was required for provisions of this Standard dealing with Isolation. The facility provided examples of the screenings used to inform placement decisions, including of the placement of a transgender resident of the facility.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires the agency to provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Also, the agency is to provide a way for residents to report abuse or harassment to an entity that can receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Staff are to accept reports made verbally, in writing, anonymously, and from third parties, and they are to promptly document verbal reports. Facilities are to provide residents with access to tools necessary to make a written report. The agency also is to provide a method for staff to privately report sexual abuse and sexual harassment of residents. The PREA Audit Interim Report stated that, “Policies and flyers were provided but not proof of practice. Three test reports to the Governor's Constituent Services Office failed. The first was because the wrong address was provided, but the agency has not indicated why the other two tests failed or what they are doing to assure their system works, or that the Governor's Constituent Services Office knows what to do with reports they receive. A fourth test letter went through, but this is not enough to show systemic and sustained compliance. One allegation was provided that was received through another source and reviewed for investigation. The report is a positive indication that this Standard is in practice. However, additional verification is needed when there is contradictory evidence. All listed reporting systems should be demonstrated to be working.” Corrective Action: The CAP required that the agency test the Governor's Constituent Services Office reporting system and provide the result of the test to the Auditor. Additionally, they were to provide proof that the Governor's Constituent Services Office has been trained, and that it understands how they are supposed to handle reports they receive, what is considered timely, and regarding reports with requests for residents or reporting parties to remain anonymous. Finally, they were required to provide systemic change so that the Governor's Constituent Services Office contact information will always be accurate when given to residents, and that the GCS Office will keep staff trained over time, and that they have a backup system for if they cannot check their mail or have other disruptions. Analysis: Documentation reviewed includes the Hotline Contact Cards given to everyone; Intake Close Custody Youth Safety Orientation YA 4033 – 2019; Hotline Poster for Facility; Link to Youth Sexual Safety video; Report Abuse OYA Hotline Poster; Youth Sexual Safety Education YA 4034; Youth Safety Guide 2020 [Residents are instructed to report abuse in a letter to the Governor's Office for Constituent Services. They are informed that this office is not part of OYA. (Governor's Constituent Services Office; 900 Court Street, Suite 254; Salem, OR 97301)]; Policy I-E-6.0 Contact with ICE; Policy I-A-10.00 Preventing Youth Sexual Abuse (Pg. 15, C); Policy 0-2.3 Mandatory Reporting of Abuse; Policy FAC I-E-4.0 (Pg. 3); Policy II-F-1.1 Youth Grievance Process (Pg. 3, E); FAC I-E-4.0.docx; updated YIR; https://www.oregon.gov/oya/Forms/YA1300.pdf; Policy II-F-1.1 Youth Grievance Process- Facility; Policy II-F-3.6 Youth Legal Materials and Assistance; Policy 0-2.3 Mandatory Reporting; https://www.oregon.gov/oya/pso/Pages/OnlineComplaintForm.aspx (see contact options); Intro and Annual PREA Training; https://youtu.be/LTetpd2vdo4; Resident reporting - agreement, process, and documentation of the test of the system. Reporting materials are also provided in Spanish and can be translated into other languages as needed. All documentation required during the CAP was provided. During the Corrective Action Process, it was learned that at least one letter sent to the GCS was sent to the Department of Corrections by mistake. Once corrections were made as required by the CAP, a test letter was sent through the mail, and the PC received confirmation of receipt in two days. A triangulation of evidence confirms that the agency is in compliance with this Standard.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA has an administrative procedure for dealing with resident grievances regarding sexual abuse. The facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, nor to otherwise attempt to resolve with staff an alleged incident of sexual abuse. Policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. Policies and blank forms were provided during the Pre-Audit Process, but not proof of practice. Corrective Action: The CAP required the PREA Coordinator to test the grievance system and provide documentation of a successful test. Additionally, as proof of practice, the facility was to provide 2 examples of actual grievances and their associated files. The CAP stated that “If none are available regarding sexual abuse, provide grievances regarding some other issue, to demonstrate that the system works. If none are available during the past year, provide some from the year before. Any new grievances regarding sexual abuse or sexual harassment must be reported to the Auditor throughout the duration of the CAP.” Analysis: The following were considered as evidence: Policy II-F-1.1 Youth Grievance Process; Administrative Remedies process and sample; PAQ; and documentation completed in satisfaction of the CAP, as described above. The test grievance was successful, and the real grievances provided also served to verify that the grievance system is working. This, along with interviews conducted and training and educational materials reviewed, demonstrates compliance.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility is required to provide residents with access to outside victim advocates for emotional support services related to sexual abuse, and by providing, posting, and otherwise making accessible the mailing addresses and telephone numbers of local, state, or national victim advocacy or rape crisis organizations. The facility is to provide residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents or legal guardians. During the Pre-Audit process, some applicable policies were provided, but not proof of practice. Additionally, the SANE location listed was not a SANE location, according to what the Audit Team was told when attempting to verify the information provided to residents and staff. The number posted for the victims' advocates was outdated and now used by an adult (porn) talk service. Corrective Action: The CAP required the agency to 1) Upload policies about legal assistance, and parent or guardian involvement. 2) Provide proof of legal assistance access, and about parent/guardian visits. 3) Review Frequently Asked Questions on the PREA Resource Center website. 4) Contact PRC for assistance. 5) Make sure the SANE locations and advocate numbers listed on materials given to residents and staff are accurate, and provide digital photos of current postings, if changes have been made. Make sure to remove inaccurate information. 6) Provide updated documents for the Auditor to review and verify, including efforts to update relevant postings, plans, brochures, handbooks. Analysis: Interviews with randomly selected residents were conducted. The PREA Compliance Manager and the Superintendent were interviewed. The following documents were reviewed: Policy IA-10.0 Preventing Youth Sexual Abuse (Pg. 8, D 6 & Pg. 16, 5); Youth Safety Guide 2020 Spanish; Youth Safety Guide 2020 English; PREA Advocacy Flyer - Updated 2020; Policy II-F-1 0 Youth Rights (Facilities); Policy II-F-3.0 Youth Mail in Facilities; Policy II-F-1.1 Youth Grievance Process - Facility; Policy II-E-2.5 Visits with Youth; Policy II-F-3.4 Youth Use of Telephone; Policy II-F-3.6 Youth Legal Materials and Assistance; Intake Close Custody Youth Safety Orientation YA 4033 – 2019; Policy II-F-3.4 Youth Use of Telephone; Policy I-A-10.0 Preventing Youth Sexual Abuse J (Pg. 9, E); Intake Close Custody Safety Orientation YA 4033; MOU with Sexual Assault Support Services; Residents' access to outside support - Advocate MOU; Advocate and SANE Annual Check (to see if information is correct) – CFYTF; Advocacy Flyers – Sexual Assault Support Services; CFYTF PCM Duties - Authority and Time; Notification to PREA Coordinator process; Access to Outside Support Services; Third-party reporting sample; documentation of resident access to legal representation and parents/guardians (proof of practice); Forensic medical exam verification; and receipt of victim advocate information verification. Upon completion of the CAP, the facility has demonstrated compliance with this Standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	According to OYA policy, they provide methods to receive third-party reports of resident sexual abuse or sexual harassment. Any staff member is required to take complaints. Complaints can be anonymous. Information is supposed to be distributed on how to report resident sexual abuse or sexual harassment on behalf of residents. Issues identified in the early 2020 round of Pre-Audit work included issues with the reporting system. The outside reporting system failed three test letters. The address was incorrect, but even after it was corrected, two other tests failed. The Auditor said, “Policies were provided but not proof of practice.” Corrective Action: The CAP required that a third party test the system by completing an online complaint form and providing documentation of the test result. It also required the agency to provide an example of an actual third-party report being received. Analysis: In addition to the information received during interviews, during the On-Site Review, and in the documentation provided during the CAP (as described above), the Audit Team also reviewed the online link (https://www.oregon.gov/oya/pso/Pages/abuse.aspx); Youth Safety Guide 2020 Spanish; Youth Safety Guide 2020 English; Residents’ access to outside support - Advocate MOU; Notification to PREA Coordinator process; Third-party reporting sample; and Resident access to legal representation, as providing insight into compliance with this Standard. There is a triangulation of evidence of compliance with this Standard.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	All staff are required to report, immediately and according to agency policy: any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred; any retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or to retaliation. OYA requires all staff to comply with any applicable mandatory child abuse reporting laws, as well as reports, as (and when) appropriate, to licensing agencies and Adult Protective Services. Other than when reporting to designated supervisors or officials and to designated state or local service agencies, OYA policy prohibits staff from revealing any information related to a sexual abuse report to anyone, beyond what is necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are mandated reporters; so, they are required to inform residents, at the initiation of services, of their duty to report, and of the limitations of confidentiality. Upon receiving any allegation of sexual abuse, OYA is to promptly report the allegation to the appropriate agency office, and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing that the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker, instead of to the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record, within 14 days of receiving the allegation. Policies supporting compliance were provided during the Pre-Audit process, but not proof of practice. Corrective Action: The CAP required the agency to provide screen shots of their review process for Youth Incident Reports (YIRs), to test whether staff are reporting everything they are required to report. Also, the agency was to provide additional information to staff about things they may have forgotten that they need to report, such as risks, retaliation, and threats. Analysis: Materials reviewed for this Standard include Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 14, c); Policy 0-2.3 Mandatory Reporting (Pg. 5, A, 1, b, Pg. 6, 4, B); Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 10, 2); Policy I-A-10.00 Preventing Youth Sexual Abuse (Pg. 9, E); Residents' access to outside support - Advocate MOU; Advocate and SANE Annual Check CFYTF; Advocacy Flyers; CFYTF PCM Duties - Authority and Time; Notification to PREA Coordinator process; Access to outside support services; Third-party reporting sample; YIRs; allegations; and resident access to legal representation. Additionally, the training detailed in the narrative for Standard 331 assisted the agency in showing compliance with the CAP.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard in its entirety is this: “When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.” Policies were initially provided, but not proof of practice. Corrective Action: The jointly developed CAP required documentation of agency-wide examples, since residents at CFYTF had not been identified as being at substantial risk of imminent sexual abuse. Analysis: Interviews with the Agency Head designee, with the Superintendent, and with randomly selected staff and residents were conducted. Documents included the PAQ; Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 14, I, 5); and Agency protection duty example, youth movement for safety. These documents, along with private interviews conducted with residents and staff, provide a triangulation of evidence of compliance.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that “Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall 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.” The Standard also requires the notification be made within 72 hours, be documented, and that “[t]he facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.” The policy was initially provided without proof of practice. Corrective Action: Since policies were compliant with the PREA Standard, Corrective Actions focused entirely upon proof of practice. No allegations relating to this Standard involved Camp Florence, so examples were provided regarding other agency facilities. One example was regarding an allegation made to a facility, and 3 were allegations received from facilities. The actions documented were consistent with this Standard. Analysis: In addition to interviews conducted, and information provided for the PAQ, the following documentation was reviewed: Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 17, F); agency example of notification to other confinement facility; and agency examples of receiving a report from a confinement facility. The agency has completed the CAP and demonstrated compliance with this Standard.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Camp Florence has a First Responder policy for allegations of sexual abuse. Its policy requires that, upon learning of an allegation that a resident was sexually abused, the first staff to respond to the report shall: (1) separate the alleged victim and abuser; and (2) preserve and protect any crime scene, until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, those appropriate steps shall be as follows: (1) the First Responder requests 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; and (2) the First Responder should 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. There are additional notifications to be made, as in ß115.361 above. During the Pre-Audit Process, policies were provided, but not proof of practice. The Audit Team suggested that the phrase, “If youth . . .” needs to be updated in First Responder Duties, since this may be confusing when residents are adults, and 18 is given as the age of consent. Additionally, the Sexual Abuse Response Plan did not state the First Responder Duties in a way that is fully consistent with the Standard, seeming to indicate that staff who are alleged perpetrators may not be subject to all First Responder Duties. Corrective Action: The CAP required the agency and facility to 1. Provide documentation of First Responder actions being used. 2. Provide documentation of another facility’s case where alleged abuse required that the victim receive a forensic examination. 3. Provide proof that “youth” terminology use in OYA includes all people in OYA physical custody, regardless of age. 4. Correct the wording so that it is crystal-clear that First Responder Duties are to be followed, even if the alleged perpetrator is a staff. Make sure all materials are consistent. (To the extent that staff are to be treated differently, explain it.) 5. Distribute new materials, and provide the new materials as well as proof of distribution, to the Auditor. Analysis: In addition to interviews conducted, documentation was reviewed, including Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 14, C); CFYTF-II-A-10.0 Sexual Abuse Response Plan; First Responder card; Facility First Responders to Sexual Abuse Checklist; Facility SARRT Sexual Abuse Incident Checklist; and the Camp Florence TYF Sexual Abuse Response Plan and Acknowledgement (all staff are trained as First Responders). Additionally, documentation was provided consistent with the CAP, as described above. All this culminates in a triangulation of evidence that the facility is compliant with this Standard.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that “The facility 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.” The Interim Report stated, “Policies were provided, and interviews were conducted. The Coordinated Response Plan (CRP) needs to be updated for First Responder Duties and SANE information. The Sexual Abuse Response Plan does not state the First Responder Duties in a way that is fully consistent with the Standard.” Corrective Action: The facility safety response plan was reviewed and enhanced during the CAP, and protocols were established to assure that, at least annually, specific information regarding providers is checked for accuracy. The Health Services Sexual Assault Response Procedure was incorporated. All related forms and policies were reviewed to get rid of any inconsistencies or confusing wording. Analysis: The OYA Camp Florence YTF Local Operating Protocol Sexual Abuse Response Plan (AKA the Coordinated Response Plan) and CFYTF-II-A-10.0 Sexual Abuse Response Plan were otherwise consistent with the Standard. The facility provided the updated CRP and proof of distribution and training. This information, along with interviews and investigations reviewed, provides a triangulation of evidence of compliance.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Audited at Agency Level
	Auditor Discussion
	The agency has neither entered nor renewed any collective bargaining agreement that restricts the ability to protect residents from abusers. Analysis: Documentation reviewed includes the 2019 -2021 Collective Bargaining Agreement between the Department of Administrative Services and the Service Employees International Union, Local 503, OPEU. All information known to the Audit Team, including internet research and interviews with administrators, is consistent with a finding that the agency and facility are compliant with this Standard.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard requires the agency and facility to protect all residents and staff, or any cooperating individual who reports sexual abuse or sexual harassment, or who cooperates with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. The Standard describes minimum practices to provide protection against retaliation. OYA policies did not include all provisions of this Standard. Also, adequate proof of practice was not provided during the Pre-Audit phase of the Audit. The Interim Report stated, “Policies were provided but not proof of practice as required. OAS, the Audit Team, and the PRC provided instructions on what can be used as proof of practice. The PC acknowledges that the agency does not monitor for retaliation to the extent required by the Standard.” Corrective Action: The CAP required that the agency develop a retaliation monitoring protocol, and that the Camp Director take the lead in monitoring for retaliation. Additionally, they were required to implement the retaliation monitoring protocol and ultimately provide proof of practice documentation of retaliation monitoring to the Auditor. Analysis: Along with the interviews conducted agency-wide, including with residents and staff who should be monitored for retaliation, the following documents were reviewed: Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 10, F 2 & Pg. 11, H); Agency protection against retaliation; updated procedure; agency monitoring example; and Retaliation monitoring - staff - process. Although they appeared to be significantly out of compliance at the time of the Interim Report, the agency/facility was able to show a level of compliance with this Standard (through the use of agency-wide examples) by the end of August 2021, and then they were able to demonstrate institutionalization of compliance by the end of the CAP.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard requires that “Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342.” Analysis: The PAQ and Site Review indicated that the facility does not isolate residents. When a Standard does not apply, a facility is assumed to be compliant with the Standard. Residents and staff were interviewed about what happens if a resident gets in trouble or has a major rule violation. They were also asked about what happens when residents make complaints or when they are unsafe. No information indicated any lack of compliance with this Standard. Polices are found in 11-B-1.2 Use of Time out (Pg. 8, F); and I-A-10.0 Preventing Youth Sexual Abuse (Pg. 10, F 2 & Pg. 11, H). Evidence used to determine compliance with this Standard includes (1) Interviews with each of the following: the Superintendent; staff who supervise residents who lose privileges for any reason; and residents who know first-hand what happens when rules are violated at Camp Florence; (2) Facility policy that residents who allege to have suffered sexual abuse may only be placed in Isolation as a last resort, only if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged, and that this policy does not apply at Camp Florence since Isolation is not used; and (3) The Site Review. There is no indication that residents are ever placed in Isolation. No contradictory information was received. This culminates in a triangulation of evidence of compliance.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard contains numerous provisions regarding how investigations are to be conducted, but it starts with “When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.” Policies were provided during the Pre-Audit process, but not proof of practice as required. The PREA Audit Interim Report stated, in part, “Full investigative files must be provided. Fixes for the weaknesses of the investigative software must be implemented.” Corrective Action: Initially, the CAP for this Standard was the same as for Standard 322, requiring the investigations to be provided, along with full PAQ information. Once agency investigations were provided and reviewed, they were found not to fully comply with provision (g) (2) of the Standard, which requires that administrative investigations, “Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.” The agency created and initiated a new report. Analysis: In addition to interviews conducted with residents agency-wide who were alleged victims and witnesses in agency administrative investigations, and visits with staff (including Investigators) about investigative processes, documentation reviewed to verify compliance includes Policy I-D-4.0 Professional Standards Office Investigations (Pg., 4, 7, Pg., 9, 3) and investigations conducted agency-wide. Additionally, verifying completion of the CAP, the Auditor has reviewed two investigations completed using the new investigative report.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The entire Standard is as follows: “The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.” During the Pre-Audit Process, proof of practice was not provided. Corrective Action: The CAP for this Standard was the same as for Standard 322, so that the Auditor would have investigations to review for compliance determination. The investigations were received and reviewed. Investigations reviewed were from other agency facilities since there were none applicable to this Standard at this facility during the 12 months reviewed for this Audit. Analysis: Interviews with investigators and other administrators, Policy I-D-4.0 Professional Standards (Pg. 8, D), and a review of investigations conducted agencywide, indicate compliance with this Standard.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Any resident who alleges that they suffered sexual abuse is to be informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Standard provides additional rules that outline the work of informing residents. For example, it requires that all notifications described under this Standard are documented. Policies were provided by the agency during the Pre-Audit Process, but not proof of practice as required. Corrective Action: The CAP for this Standard was the same as for Standard 322, to include documentation of reporting to residents. Investigations reviewed were from other agency facilities since there were none applicable to this Standard at this facility during the 12 months reviewed for this Audit. Analysis: Upon completing interviews with investigators and administrators, and reviewing Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 10, 3, Pg. 11, b), investigations, documentation of notification of residents, and Administrative Incident Review Reports, a triangulation of evidence of compliance had been achieved.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Facility staff are to be subject to disciplinary sanctions, up to and including termination, for violating agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are to 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 histories. 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, are to be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Policies were provided during the Pre-Audit Process, but not proof of practice as required. Corrective Action: Once the PAQ was provided, and investigative documentation, the only remaining requirement relating to this Standard was proof of practice. There were no examples specific to this facility, so they agreed to provide documentation of a completed Staff-on-Youth Misconduct Violation Letter regarding a staff from another facility. Analysis: Evidence for compliance includes interviews with staff and administrators; Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 5, end of III); Policy I-D-4.0 Professional Standards (Pg. 9, J); Sample of disciplinary sanctions for staff; and investigative materials.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that “Any contractor or volunteer who engages in sexual abuse shall be 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.” It also requires that “The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.” Policies were provided during the Pre-Audit process, but not proof of practice as required. OAS, the Audit Team, and the PRC provided instructions on what can be used as proof of practice. Corrective Action: No contractor or volunteer is known to have committed sexual abuse against a resident, so for proof of practice, the agency provided a documented example of a contractor being prohibited from entering an agency facility due to policy violations other than sexual abuse. Analysis: Evidence of compliance includes interviews conducted, documentation reviewed, and completion of the CAP. Documentation includes Agency Policy I-D-4.0 Professional Standards (Pg. 3, f, Pg. 9, J); Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 6, 5, B); and corrective action for contractors and volunteers – agency example.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Residents are to be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. This Standard provides guidelines for disciplinary sanctions for sexual abuse. It prohibits disciplinary action for a report of sexual abuse made in good faith, based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Sexual activity between residents does not constitute sexual abuse unless the activity is coerced. Policies related to this Standard were provided during the Pre-Audit process, but not proof of practice. OAS, the Audit Team, and the PRC provided instructions on what can be used as proof of practice. Corrective Action: Once the policies and procedures were verified, the CAP focused on locating and providing proof of practice, which was provided in the form of Youth Incident Report (YIR) summaries, and screenshots of YIR refocus actions. This process also strengthened the evidence of compliance with other PREA Standards that need the agency to document its work with residents in its care, and to be able to track and locate that data when needed. This activity helped demonstrate the type of collaboration that occurs between agency and facility officials, the functionality of their software, and the way a facility which receives a resident from another facility (within OYA) has access to information necessary to care for that resident. Additionally, interventions regarding residents exhibiting harassing or bullying behavior, even if not resident-on-resident sexual abuse, were reviewed in relationship with this Standard. Analysis: PAQ, interviews, and the On-Site Review indicated that Camp Florence does not isolate youth. Therefore, other management strategies are used, including moving an offending resident to another facility. Although the facility administrators indicate an understanding of this Standard, they have not had applicable substantiated allegations of sexual abuse by youth at the facility in the past 12 months. Examples of practice are from older files, other facilities, or other types of behavior problems. Documents reviewed include Policy II-B-2.1 Behavior Mgt - Youth Refocus Options (2); Policy II-B-2.1 Behavior Management Attachment A; Policy II-B-1.2 Use of Time Out (Pg. 9, G); Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 4, III, Pg. 10, 2, & Pg. 16, E). These policies came with agency-wide examples of the policies (and this Standard) being followed in practice. Since concerns had been raised regarding bullying at the facility, documentation was also provided verifying that residents are refocused, and that this is done consistent with this Standard. Taken with the interviews conducted throughout this Audit, with both residents and staff, and a review of investigative materials, the facility demonstrates compliance with this Standard.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard relates to the screening conducted for Standard 115.341. When residents have experienced prior sexual victimization, or if residents have previously perpetrated sexual abuse, staff are required to ensure that the residents are offered a follow-up meeting with a mental health practitioner within 14 days of the screening. The Standard also provides rules regarding information related to sexual victimization or abusiveness. The PREA Audit Interim Report stated that "Policies were provided but not proof of practice as required. OAS, the Audit Team, and the PRC provided instructions on what can be used as proof of practice." Corrective Action: Once policies and procedures were verified, the CAP focused on ways proof of practice could be provided. The agency and facility provided copies of completed YA 4409 (MH screening); YA 4416 (Health Screenings); and MASIs. They highlighted the sexual abuse components of the forms. They provided documentation of follow-up when there is a history of sexual abuse, with screen shots of case notes. Analysis: Policy and procedure documentation includes Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 13, 4); SVAT Checklist for the facility; OYA Informed Consent-Awareness of Information Sharing - 12.1.14; Disclosure of Confidentiality Limitations; and Authorization for Release of Information. Proof of practice included lengthy Mental Health Screening documentation, including follow-up care, and screenshots associated with residents applicable to this Standard. Files provided proof of practice documentation of mental health screenings and follow-ups for 5 Camp Florence residents. Taken with the interviews conducted, this culminates in a triangulation of evidence of compliance.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Resident victims of sexual abuse are to receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are to be determined by medical and mental health practitioners, in accordance with their professional judgment. Medical and mental health staff are to maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. Treatment services are to be provided to every victim without financial cost, and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policies were provided during the Pre-Audit process, but not proof of practice, as required. OAS, the Audit Team, and the PRC provided instructions on what can be used as proof of practice. PeaceHealth Harbor Medical Center is the emergency medical services provider for Camp Florence. Corrective Action: Once policies and procedures were verified, the CAP focused on ways proof of practice could be provided. Since the facility did not have any allegations requiring emergency medical services for a sexual assault, they provided documentation of an incident requiring emergency medical care unrelated to sexual abuse. The documentation of the incident included appropriate notifications to medical and QMHP staff. Analysis: Documents reviewed included Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 2, B, Pg. 15, D & Pg. 16, 4); and an example of access to emergency medical services. These documents were consistent with what the Audit Team learned about what residents and staff believe are their responses to emergencies. Policies and procedures, along with interview evidence and proof of practice documentation, provides a triangulation of evidence that the facility is compliant with this Standard.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility is required to offer medical and mental health evaluations, and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse while incarcerated are to be offered tests for sexually transmitted infections, as medically appropriate. Treatment services are to be 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. Within 60 days of learning of such abuse history, the facility is to attempt to conduct a mental health evaluation of all known resident-on-resident abusers, and it is to offer treatment when deemed appropriate by mental health practitioners. Policies were provided, but not proof of practice as required. OAS, the Audit Team, and the PRC provided instructions on what could be used as proof of practice. Corrective Action: Once policies and procedures were verified, the CAP focused on ways proof of practice could be provided. The agency and facility provided copies of completed YA 4409 (MH screening); YA 4416 (Health Screenings); and MASIs. They provided documentation of follow-up when there is a history of sexual abuse, with screen shots of case notes. There were 5 cases provided as agency-wide proof of practice. Analysis: Documents reviewed included Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 13, 4 & Pg. 16, 4); Policy HS IA-10.0 Preventing Youth Sexual Abuse (Pg. 1 & Procedure Statement); SVAT Checklist for the facility; OYA Informed Consent-Awareness of Information Sharing - 12.1.14; Disclosure of Confidentiality Limitations; and Authorization for Release of Information. Proof of practice included lengthy Mental Health Screening documentation, including follow-up care, and screenshots associated with residents applicable to this Standard. Taken with the interviews conducted, this culminates in a triangulation of evidence of compliance.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires facilities to conduct a sexual abuse Incident Review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded; and it should do so within 30 days of the conclusion of the investigation. The sexual abuse Incident Review Team should include upper-level management officials and allow for input from line supervisors, investigators, and medical or mental health practitioners. The Review Team should consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; examine the area in the facility where the incident allegedly occurred, to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepare a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submit such report to the facility head and to the PREA Compliance Manager. Based on the limited documentation received during the Pre-Audit process, the PREA Audit Interim Report indicated that more investigative documentation needed to be reviewed. Corrective Action: Once full investigative documentation was provided, it became more apparent that the conducting of sexual abuse Incident Reviews is institutionalized in the agency culture, but not to a degree that the documentation verifies full compliance with all provisions of the Standard. The CAP required the agency to update the Incident Review policy to include requirements of AIR team members when completing a sexual abuse Incident Review (input from supervisory line staff, medical or mental health practitioners); update AIR Report YA 0024 to include what materials were reviewed, and who interviewed; provide documentation that the AIR reports were completed within the required time frame; provide documentation of what PSO provides the AIR team; and upload completed Incident Reviews to OAS. Analysis: Interviews with administrators and Investigators verified that these Reviews occur. Documents reviewed for compliance determination include Policy I-A-10.0 Preventing Youth Sexual Abuse (Pg. 17, G); Administrative Incident Review Report; Agency I-E-4.0 Incident Reviews; Sexual Abuse Incident Reviews - Administrative Incident Review Report – revised; Sexual Abuse Incident Reviews Updated Policy; Sexual Abuse Incident Reviews before and after updated policy and revised form; and Documentation of the training and implementation process for the policy update and revised form. Information from interviews, policies, procedures, and proof of practice verify compliance with this Standard.

115.387	Data collection
	Auditor Overall Determination: Audited at Agency Level
	Auditor Discussion

115.388	Data review for corrective action
	Auditor Overall Determination: Audited at Agency Level
	Auditor Discussion

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Audited at Agency Level
	Auditor Discussion

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires all facilities be audited at least once during each 3-year audit cycle and provides rules for how this is to happen. It includes a provision which states that “The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information).” The PREA Audit Interim Report stated, “Evidence used to determine compliance with this Standard includes details regarding when the facility, and other facilities within the agency, have had audits. Also considered were observations of the lack of requested documentation and acknowledgments by the agency that PAQ information was missing.” Corrective Action: One of the highest priorities after the PREA Audit Interim Report was for the Agency and Facility to provide all the materials needed. This was quickly accommodated, and the agency has continued to provide documentation throughout the 180-day CAP. Analysis: At the writing of this PREA Audit Final Report, the agency has demonstrated compliance for 6 months, showing proof of a measure of institutionalization of this practice.

115.403	Audit contents and findings
	Auditor Overall Determination: Audited at Agency Level
	Auditor Discussion

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	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
	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
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	
	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".)	na

115.313 (a)	Supervision and monitoring	
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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

115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	yes
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	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
	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
	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
	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
115.313 (e)	**Supervision and monitoring**	
	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
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	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
115.315 (a)	**Limits to cross-gender viewing and searches**	
	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
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes

115.315 (c)	Limits to cross-gender viewing and searches	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	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
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	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
115.315 (e)	**Limits to cross-gender viewing and searches**	
	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
	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
115.315 (f)	**Limits to cross-gender viewing and searches**	
	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
	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

115.316 (a)	Residents with disabilities and residents who are limited English proficient	
	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
	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
	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
	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
	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
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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
115.317 (a)	**Hiring and promotion decisions**	
	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
	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
	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 bullet immediately above?	yes
	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
	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
	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 two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	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
115.317 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	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
	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
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes

115.317 (e)	**Hiring and promotion decisions**	
	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
115.317 (f)	**Hiring and promotion decisions**	
	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
	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
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	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
115.318 (a)	**Upgrades to facilities and technologies**	
	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
115.318 (b)	**Upgrades to facilities and technologies**	
	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
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	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

115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	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
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	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
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	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
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	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
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	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.)	na

115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	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
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	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
	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
	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
	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
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes

115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	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
115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	no
115.332 (a)	**Volunteer and contractor training**	
	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
115.332 (b)	**Volunteer and contractor training**	
	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
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes

115.333 (b)	**Resident education**	
	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
	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
	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
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	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
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	
	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
115.334 (a)	**Specialized training: Investigations**	
	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

115.334 (b)	**Specialized training: Investigations**	
	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
	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
	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
	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
115.334 (c)	**Specialized training: Investigations**	
	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
115.335 (a)	**Specialized training: Medical and mental health care**	
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	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 or the agency does not employ medical staff.)	yes
115.335 (c)	**Specialized training: Medical and mental health care**	
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341 (a)	**Obtaining information from residents**	
	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
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	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
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	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

115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	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
115.342 (a)	**Placement of residents**	
	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
	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
	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
	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
	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
115.342 (b)	**Placement of residents**	
	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
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	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
	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
	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
	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
115.342 (d)	**Placement of residents**	
	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
	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
115.342 (e)	**Placement of residents**	
	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
115.342 (f)	**Placement of residents**	
	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
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	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?)	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?)	na
115.342 (i)	**Placement of residents**	
	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

115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	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
115.351 (b)	**Resident reporting**	
	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
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	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
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	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.	no
115.352 (b)	**Exhaustion of administrative remedies**	
	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
	Does the agency always refrain from requiring an 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

115.352 (c)	**Exhaustion of administrative remedies**	
	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
	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
115.352 (d)	**Exhaustion of administrative remedies**	
	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
	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
	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
115.352 (e)	**Exhaustion of administrative remedies**	
	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
	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
	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
	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
	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

115.352 (f)	**Exhaustion of administrative remedies**	
	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
	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
	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
	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
	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
	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
	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
115.352 (g)	**Exhaustion of administrative remedies**	
	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
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	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 accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	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
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	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
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes

115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	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
115.361 (d)	**Staff and agency reporting duties**	
	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
	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

115.361 (e)	**Staff and agency reporting duties**	
	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
	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
	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
	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
115.361 (f)	**Staff and agency reporting duties**	
	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
115.362 (a)	**Agency protection duties**	
	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
115.363 (a)	**Reporting to other confinement facilities**	
	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
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.364 (a)	**Staff first responder duties**	
	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
	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
	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
	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
115.364 (b)	**Staff first responder duties**	
	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
115.365 (a)	**Coordinated response**	
	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
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	
	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
115.367 (a)	**Agency protection against retaliation**	
	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
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	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

115.367 (c)	**Agency protection against retaliation**	
	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
	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
	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
	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
	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
	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
	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
	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
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	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
115.368 (a)	**Post-allegation protective custody**	
	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
115.371 (a)	**Criminal and administrative agency investigations**	
	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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes

115.371 (b)	**Criminal and administrative agency investigations**	
	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
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	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
115.371 (f)	**Criminal and administrative agency investigations**	
	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
	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
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.371 (h)	**Criminal and administrative agency investigations**	
	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
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	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
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes

115.371 (m)	**Criminal and administrative agency investigations**	
	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
115.372 (a)	**Evidentiary standard for administrative investigations**	
	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
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	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
115.373 (c)	**Reporting to residents**	
	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
	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
	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
	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
115.373 (d)	**Reporting to residents**	
	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
	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
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes

115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	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
115.376 (d)	**Disciplinary sanctions for staff**	
	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
	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
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	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
115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	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

115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	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
	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
	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
	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
	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
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	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
	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
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	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
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	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

115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.382 (a)	**Access to emergency medical and mental health services**	
	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
115.382 (b)	**Access to emergency medical and mental health services**	
	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
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	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
115.382 (d)	**Access to emergency medical and mental health services**	
	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
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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.)	na

115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.386 (a)	**Sexual abuse incident reviews**	
	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
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	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
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes

115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes