PREA Facility Audit Report: Final

Name of Facility: Ridgeview Community Facility
Facility Type: Juvenile
Date Interim Report Submitted: 12/02/2019
Date Final Report Submitted: 07/01/2020

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: Kyle D. Barrington	**Date of Signature:** 07/01/2020

AUDITOR INFORMATION	
Auditor name:	Barrington, Kyle
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Telephone number:	979-696-6373
Start Date of On-Site Audit:	10/21/2019
End Date of On-Site Audit:	10/25/2019

FACILITY INFORMATION	
Facility name:	Ridgeview Community Facility
Facility physical address:	1726 Jerome Ave., Yakima, Washington - 98902
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	LeeAnn Delk
Email Address:	leeann.delk@dcyf.wa.gov
Telephone Number:	5093678713

Superintendent/Director/Administrator	
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Facility PREA Compliance Manager	
Name:	
Email Address:	
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Name:	LeeAnn Delk
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Telephone Number:	

Facility Characteristics	
Designed facility capacity:	16
Current population of facility:	7
Average daily population for the past 12 months:	7
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	
Age range of population:	12-24
Facility security levels/resident custody levels:	minimum
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:	1

AGENCY INFORMATION	
Name of agency:	Washington State Department of Children, Youth, and Families
Governing authority or parent agency (if applicable):	Washington State Department of Social and Health Services
Physical Address:	1115 Washington St. SE, Olympia, Washington - 98504
Mailing Address:	
Telephone number:	360-902-8088

Agency Chief Executive Officer Information:	
Name:	Marybeth Queral
Email Address:	QueraMB@dshs.wa.gov
Telephone Number:	360-902-7957

Agency-Wide PREA Coordinator Information			
Name:	Eric Crawford	**Email Address:**	eric.crawford@dshs.wa.gov

AUDIT FINDINGS

Narrative:
The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

Washington State's Department of Children, Youth, and Families' (DCYF) Juvenile Rehabilitation division requested a PREA audit for its Ridgeview Community Facility (RCF) requested a on July 18, 2019. The RCF is located in Yakima, Washington and the pre-audit work began on September 4, 2019 and the onsite portion of the PREA Audit was conducted between October 21, 2019 and October 25, 2019. (NOTE: For the purposes of this PREA Report the term "Agency" always refers to DCYF and the term "Facility" always refers to the RCF).

The Data Audit Framework used by this auditor to assess the Agency's and Facility's compliance with the PREA Standards included the following: (1) Agency policies, (2) Facility procedures, (3) Interviews with 27 people [Agency Head designee, PREA Administrator, HR Manager, Investigator, Facility Director, Staff who perform Screening for Risk of Victimization and Abusiveness, Intake Staff, and Staff Responsible for Retaliation Monitoring, 10 security staff and 9 residents], (4) the Pre-Audit Questionnaire, (5) 23 client files, (6) 14 staff files and (7) associated attachments. Further, the Data Audit Framework relied on interviews of local area service providers [e.g., local area rape crisis center and local hospitals that would be used for forensic exams] and interviews with local police department staff and local school district staff.

To complete this audit, this auditor used a triangulated audit methodology. First, all submitted and related documentation was reviewed. This included policies, procedures, organizational charts, forms, etc. After a thorough review of the documentation was completed, this auditor conducted interviews [semi-structured and unstructured] of staff, residents, and other stakeholders [local community-based organizations who provide victim advocacy services to residents, as well as, interviewing staff from the agencies responsible for investigating sexual abuse and sexual harassment allegations at the facility]. Once the interviews were completed, the auditor reviewed files, and reports. This allowed the auditor to determine if the agency and facility were complying with all related PREA standards.

An important part of the audit methodology was the site tour and review. On October 23, 2019, an auditor toured the RCF. A review of the facility allowed the auditor to: (1) note obvious blind-spots; (2) observe the areas were residents typically shower, change clothes, and/or perform bodily functions; (3) note staff locations and movements; (4) record resident supervision levels; and (5) observe the types and abundance of communications between the facility and residents, via posters and notices.

To ensure that the audit process was fair and transparent, the auditor utilized a random selection process, using a random number generator, to identify security staff, residents, and files for review. At the beginning of the audit, the auditor asked for four lists. The lists were: (1) Current security staff; (2) Current residents; (3) Staff who were promoted within the past 12-months; (4) List of contractors and volunteers; and (5) Residents who discharged within the past 12-months. This auditor placed a number next to each name, on each list, starting with the number one (1) and moving upward in a sequential manner. Once all current security staff members were numbered, this auditor utilized a computerized

random number generator to identify the security staff that were selected for interviews. This ensured that every security staff member had an equal chance of being selected for an interview. Careful attention was paid to ensure that security staff from all shifts were selected and that security staff assigned to different housing areas were selected. Once this was completed, this auditor repeated this process for each of the remaining lists. In all, this auditor interviewed 10 security staff, 100.0% of the residents, 14 staff files, and 23 files of residents.

AUDIT FINDINGS

Facility Characteristics:
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Ridgeview Community Facility (RCF) is a single building property with two "out" buildings. The two outbuildings are used as storage sheds and are located beside the main facility. The main building is a single-story structure with one (1) single occupancy room and seven (7) double occupancy rooms. The main floor is divided into two housing units that correspond to the two residential hallways. Of the 8 rooms, 3 are in a "small hallway" and the remaining 5 bedrooms are in a separate "long" hallway.

Ridgeview has a designed capacity of 16. The facility is designed to house residents aged 12 to 24. The facility's security level is rated as a "minimum" and the resident custody levels range is considered "minimum" per interviews with DCYF staff. RCF is not considered a "secure" facility as residents are expected, and required, to leave the facility and take part in community activities (e.g., school, work, volunteer, etc.). As of October 2019, the facility was authorized to employ up to 20 staff members. Staff members employed at the facility include males and females. During the overnight shift, agency policy requires two staff to be present. All staff are considered 'security' staff for the purpose of the staff-to-resident ratio as defined by PREA. The facility has multiple security cameras located in and around the facility but none of the cameras are in the resident's bedroom or shower/toileting areas. Educational services are provided at an onsite classroom and via the local public schools. After classes, the residents are encouraged to find employment within the community.

Medical care is provided off-site at local area medical clinics and hospitals. Mental health services are provided by off-site counselors and therapists.

The facility does not have its own investigators. Criminal investigations are handled by a referral to Child Protective Services, local law enforcement and/or the Washington State Patrol. Administrative investigations are handled by JR staff and, in some cases, DCYF staff who are currently based in Olympia, Washington, about 175 miles away.

AUDIT FINDINGS

Summary of Audit Findings:
The OAS will automatically calculate the number of standards exceeded, number of standards met, and the number of standards not met based on the auditor's compliance determinations. If relevant, the auditor should provide the list of standards exceeded and/or the list of standards not met (e.g. Standards Exceeded: 115.xx, 115.xx..., Standards Not Met: 115.yy, 115.yy). 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:	3
Number of standards met:	40
Number of standards not met:	0

Prior to the onsite audit, which occurred on October 21, 2019 and ended on October 25, 2019, it was confirmed, via photographic email evidence provided by the PREA Compliance Manager, that the required PREA Audit notices were posted. That evidence confirmed that the notices were posted in various, conspicuous areas throughout each building that comprises the Facility.

On October 1, 2019, this Auditor received an electronic package containing the completed Pre-Audit Questionnaire, agency policies and facility procedures via the Online Auditing system. Upon review of the information and data provided, it became clear that the Agency and the Facility had taken several steps toward meeting PREA compliance. A conference call with this Auditor and the PREA Compliance Manager at the facility was conducted on October 17, 2019. This call confirmed that the Facility had made progress toward PREA compliance and confirmed that the Facility was ready for the onsite portion of the PREA Audit.

The first two days (October 21, 2019 and October 22, 2019) of the onsite portion of the audit was conducted at the Agency headquarters in Olympia, Washington. This auditor interviewed the Agency Head designee, PREA Administrator, Contract Specialist, Investigator, and an HR staff member. This auditor also reviewed policies and procedures and reviewed results of investigations. During this agency audit it was confirmed that in July of 2019, the Department of Juvenile Rehabilitation for the State of Washington was moved from under the auspices of the Washington State Department of Social and Health Services (DSHS) to being under the auspices of the newly created Washington State Department of Children, Youth and Families (DCYF). The DCYF is the agency that oversees the Juvenile Rehabilitation (JR) division. JR serves Washington state's highest-risk youth and the Ridgeview Community Facility is operated by the JR division. This move has resulted in some significant challenges for the JR division as it relates to PREA. As an example, all the PREA policies and procedures were originally written and approved when the agency was under DSHS control. Now that the agency is under DCYF supervision several components of these policies and procedures are no longer applicable. Further, the change between agencies has resulted in additional bureaucratic layers which drew stronger scrutiny related to the authority vested in the PREA Coordinator (called the PREA Administrator) position. Further, the old agency, DSHS, had a standing Memorandum of Understanding with the Washington State Patrol authorizing the Washington State Patrol to investigate all allegations of sexual abuse and

sexual harassment. However, now that JR is not under the auspices of DSHS, the Washington State Patrol is no longer willing to take on this extra investigation responsibilities. This has resulted in significant changes to the investigation practices have not been captured in the JR policies and procedures.
The facility onsite audit was conducted on October 23, 2019 to October 25, 2019. On the first day of the facility onsite audit, which stated on October 23, 2019, an introduction meeting was held at approximately 9:00 AM with the Facility Director for RCF who was also the PREA Coordinator. It was noted that there were nine female residents onsite at the time of the audit but that two had gone “absent without leave.” Following this meeting a tour of the entire Facility was conducted and this Auditor noted the layout of the physical grounds and the various structures. Additionally, this auditor observed posted notices about this PREA Audit, as well as, some posted notices regarding the rights of the residents to be free from sexual abuse. During this tour, it was noted that there were a few "blind spots" but these areas had been noted by Facility staff. It was also noted that there were multiple security cameras in the Facility but none of the cameras where in areas where residents would be showering, changing clothes, or performing bodily functions.
While participating in the tour, the Auditor observed residents being supervised by the Facility Staff (i.e., security staff). During the onsite, the auditor formally interviewed 100.0% of the residents. Residents reported being informed of the Facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and of their right to be free from sexual abuse and sexual harassment, as well as, their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. All residents interviewed stated they did receive their PREA Education at time of intake. However, a review of client files found that several resident files did not contain evidence that the residents attended these trainings and education sessions or provided evidence that the information was provided beyond the timeframe required by the PREA standards.
As part of the routine work assignment during the onsite portion of this PREA Audit, the auditing team interviewed a total of 10 security staff. All 10 were randomly selected security staff. The security staff interviewed represented staff from all shifts. In addition, the auditing team interviewed five (5) specialized staff, to include, the Facility Director, the PREA Compliance Manager, Staff who perform Screening for Risk of Victimization and Abusiveness, Intake Staff, and Staff Responsible for Retaliation Monitoring. Overall, the staff interviews revealed that all staff were trained in the PREA Standards. Staff appeared confident about their roles as first responders and all had consistent answers on how a resident was to report sexual abuse and/or sexual harassment. Staff responsible for conducting intake risk assessments noted that they completed a risk screening. A review of the screening tools noted that they were objective and did collect all the information required by PREA.
By the end of the audit it was determined that the agency and facility have done a lot of work to ensure the facility is safe. However, as mentioned above, the change from DSHS supervision to DCYF has resulted in significant challenges. Further, the ability to retain documentation of compliance with PREA standards, specifically related to resident PREA information upon intake and PREA education, within 10-days of intake, has been a struggle.

After the onsite portion of this PREA Audit, it was determined that the Facility “Exceeds Standard” on three PREA Standards (315 & 342); “Meets Standard” on 28 PREA Standards, and “Did Not Meet Standard” on 10 PREA Standards (311, 313, 317, 322, 331, 333,341, 354, 367, and 376).

A corrective action plan was initiated, and the corrective action plan period began on December 5, 2019.

During the Corrective Action Plan Period, the agency and facility staff were able to complete all Corrective Action Plan items. Thus, at the end of the Corrective Action Plan period all standards were deemed to meet or exceed standard.

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
	REQUIREMENTS: 115.311: This standard has three components (a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct; (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities; and (c) Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, this Auditor reviewed the following: 1) JR Policy number 5.90 [Signed 5/20/2019]; 2) Interviews with the designee for the Agency Head, 3) Interview notes with the PREA Coordinator [entitled the PREA Administrator within the Agency] and the Facility PREA Compliance Manager, 4) the Pre-Audit Questionnaire; 5) DCYF's Organizational Chart; 6) The Facility's Organizational Chart; 7) Facility Preamble and 8) Interviews with staff. OBSERVATIONS: The Agency's 5.90 Policy covers all required elements of 115.311, however, there are still references to DSHS which no longer includes JR. Of particular importance are the sections under staff sanctions that relate to DSHS policies and procedures that JR staff are responsible for following even though JR staff are not under the auspices of DSHS. The Agency employees a PREA coordinator, entitled the PREA Administrator, with sufficient time to develop, implement, and oversee the efforts to comply with the PREA standards in all of its facilities. However, since the transition into DCYF, the PREA Coordinator does not appear to be "upper level" nor does it appear the PREA Coordinator is an "agency-wide" position. The Facility does have a designated PREA Compliance Manager but the PREA Compliance Manager does not believe they have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. DETERMINATION: The agency and facility do not meet this standard. RATIONALE: The Zero-Tolerance Policy needs to be updated. There are two elements related to this component of the standard. First, that the agency has a written policy mandating zero tolerance toward all forms of sexual and sexual harassment. Based on a review of the policies, the agency and facility meet this element. The second element is that the written policy outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Based on the observations noted above it was determined that the Agency DOES NOT meet this component of the Standard. Currently, the JR division is under the direction of DCYF. DCYF assumed supervision of JR earlier in 2019 after state lawmakers changed the laws and moved JR from under DSHS and placed them under DCYF. However, Policy 5.90 still references DSHS under staff sanctions. DSHS should be changed to DCYF as DSHS no longer supervises JR. Further, in the Facility's Preamble, under responses to allegations of sexual abuse and sexual harassment it is referenced that

the facility has its own investigators but the audit revealed that the facility would rely on an investigator from Olympia, thus the facility does not have its own investigators. In addition, the Facility's Preamble references, in at least two places, JRA or JJ&RA, which no longer exits. Finally, the facility uses additional screening tools that are not noted in their "Strategies and Responses to Reduce and Prevent Sexual Abuse and Sexual Harassment of Residents."

A second component of this standard is that the Agency hire a PREA Coordinator. There are three specific elements to this component of the standard. First, the PREA Coordinator must be agency-wide. Second, that the PREA Coordinator must be an upper-level position within the agency's hierarchy. Third, the PREA Coordinator must have the time and authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards in all its facilities. Based on a review of the legislation that created the new DCYF agency and after interviews with the agency staff, DCYF does not appear to employ or designate an upper-level, agency-wide PREA coordinator. Specifically, the PREA Coordinator, called the PREA Administrator, does not appear to have the authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards in all of its facilities. Nor does the position of the PREA Coordinator appear to be an agency-wide position. According to the interpretation from DOJ related to the definition of authority, the PREA Coordinator "must, at a minimum [emphasis added], have: (1) Direct access to the agency's most senior leader or chief executive officer (e.g., Director, Secretary, Commissioner, Administrator, etc.); (2) Direct access to the agency's executive or senior leadership team; and (3) The influence necessary to create and implement agency-wide policies, procedures, and practices, without any interference from other levels of bureaucracy or supervision [emphasis added], and in accordance with the PREA standards and interpretative guidance issued by DOJ." Currently, the following are the "other levels of bureaucracy or supervision" between the PREA Coordinator and the most senior leader or chief executive officer: The PREA Coordinator reports to the: (1) Program Administrator- Institution Programs, who in turns reports to the (2) Director of Institution Programs, who reports to the (3) Assistant Secretary of Juvenile Rehabilitation, who reports to the (4) Deputy Secretary of Programs for Children and Families, and then to reports to the (5) Secretary of DCYF. It should be noted that the only agency-wide staff is the Secretary. Thus, the PREA Coordinator must pass through 4 different administrative layers before he meets an agency-wide administrator. As the PREA Coordinator does not have direct access to the agency's most senior leader, does not have direct access to the agency's executive or senior leadership team, nor does the position appear to have the influence necessary to create and implement agency-wide policies, procedures, and practices, without any interference from other levels of bureaucracy or supervision, it was determined the agency does not meet this standard.

PREA requires that where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. This standard has two elements. First, that a PREA Compliance Manager (PCM) is designated. Second that the PCMs have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. Based on interviews, a review of the facility's organizational charts, and observations the facility does designate a PREA compliance manager but this staff member reported that they do not have the sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. Thus, this component is not met.

CORRECTIVE ACTION PLAN (CAP) OVERVIEW: Working with the PREA Administrator and the Facility Director the following CAP was developed: (1) Revise Agency Policy 5.90, with signature date of 5/20/2019, to remove DSHS in the staff sanctions section; (2) The Facility Preamble needs to be revised to ensure all agency acronyms are correct and appropriate (e.g., updated JJ&RA to reflect current organization, etc.); (3) Update the Preamble to include the added screening tools; (4) The Facility Preamble should correctly identify who the agency will utilize for investigations and this section should articulate if the investigators are different if the investigation is for criminal or administrative purposes; (5) Revise the position of the PREA Coordinator position, called the PREA Administrator within DCYF, to a position that ensures it is an upper-level, agency-wide PREA coordinator position; and (6) Work with the designated Facility PREA Compliance Manager to determine how they can have the time and authority necessary to implement the PREA standards. The facility entered into the Corrective Action Plan Period on December 30, 2019.

CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all six of the CAP items. For the issue related to item five of the CAP (i.e., “Revise the position of the PREA Coordinator position, called the PREA Administrator within DCYF, to a position that ensures it is an upper-level, agency-wide PREA coordinator position with sufficient time and authority to develop, implement and oversee the agency’s efforts to comply with the PREA standards in all of its facilities, and that this is accurately reflected in the DCYF organizational chart. To verify this is completed this Auditor will review the revised DCYF Organizational Chart and interview the PREA Administrator to ensure he/she has the time and authority to fulfill his/her obligations as the Agency’s PREA Coordinator”). During the CAP period, this auditor received a letter from the Secretary of DCYF. He noted that “JR is the unit of state government with the direct responsibility for the operation of state facilities confining juvenile residents and day-to-day decision-making. The legislature appropriates funding for Juvenile Rehabilitation. JR creates and implements its own program policies.” As this aligns with PREA’s definition of agency (i.e., Agency means the unit of a State, local, corporate, or nonprofit authority, or of the Department of Justice, with direct responsibility for the operation of any facility that confines inmates, detainees, or residents, including the implementation of policy as set by the governing, corporate, or nonprofit authority”) JR is considered its own “agency” as defined by PREA and the PREA Administrator does report to the highest levels of JR, thus this standard is meet.

FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.312: This standard has two components: (a) A public agency that contracts for the confinement of its inmates with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, this Auditor reviewed the following: 1) the Pre-Audit Questionnaire; 2) Interview with the Contract Specialist at DCYF; and 3) Interview(s) with the Agency Head, PREA Coordinator, and Facility Director. OBSERVATIONS: Interviews with the Agency Head, PREA Coordinator (called PREA Administrator), DCYF Contract Specialist, and the Facility Director supported the agency's contention that the agency does not contract for the confinement of its residents with private agencies or other entities, including other government agencies. Thus, this standard is determined to be "not applicable." DETERMINATION: Based on the observations noted above it was determined that this standard is not applicable.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.313: This standard has four components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; (c) the staffing plan is reviewed annually; and (d) for secure facilities, where unannounced rounds occur, staff are prohibited from alerting other staff that such rounds are occurring. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) Agency policy 5.90; 2) the Pre-Audit Questionnaire; 3) Facility's Staffing Plan; and 4) Interviews with staff. OBSERVATIONS: The facility developed, implemented, and documented a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the facility did take into consideration: (1) Generally accepted juvenile detention and correctional/secure residential practices; (2) Any judicial findings of inadequacy; (3) Any findings of inadequacy from Federal investigative agencies; (4) Any findings of inadequacy from internal or external oversight bodies; (5) All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated); (6) The composition of the resident population; (7) The number and placement of supervisory staff; (8) Institution programs occurring on a particular shift; (9) Any applicable State or local laws, regulations, or standards; (10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (11) Any other relevant factors. However, the latest version of the staffing plan did not include the change in state law that allows the facility to include youth aged 12 to 25. This change needs to be included in the staffing plan as it may require adjustments to the staffing plan and could result in changes to the composition of residents. In addition, there appears to be inconsistencies in the composition of the residents as it relates to the facility design. For example, in one area of the staffing plan the plan states "The facility is designed to house up to 16 residents between the ages of 12-20 years old" and in another it states "The facility is designed to house up to 16 residents, between the ages of 14-20 years old." No deviations from of the staffing plan were noted by staff during staff interviews and no deviations were reported in the Pre-Audit Questionnaire. However, staff deviation forms were available if a deviation is reported. The Staffing Plan presented to the auditor did not include signatures. Further, the Staffing Plan noted that "This staffing plan is an update of the one completed on 10-19-17" which implies no Staffing Plan was reviewed in 2018. Thus, it does not appear the staff plan is updated annually Ridgeview is not considered a secure facility. This means that unannounced rounds are not required, and none were noted. DETERMINATION: It was determined that the Facility does not meet this Standard. RATIONALE: The Staff Plan is to consider any applicable State or local laws, regulations, or standards. Prior to 2019, the agency's legal obligation for housing residents terminated upon the resident achieving the age of 21. However, a recent change to State law, changed in July

	2019, now mandates that the agency can house residents until they achieve the age of 25. This change may pose challenges to the current staffing plan and may alter the composition of residents at the facility (e.g., how will the facility ensure the safety of a younger resident, say 11, who is in the same facility with a 24-year-old?). However, this change was not noted in the 2019-2020 Staffing Plan presented to the auditor. PREA also requires that the Staffing Plan will be updated whenever necessary “but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (3) The resources the facility has available to commit to ensure adherence to the staffing plan.” In a review of the Staffing Plan, a 2018 staff plan could not be found. Thus, the Staffing Plan was not being updated and reviewed as per the PREA requirements. CORRECTIVE ACTION PLAN (CAP) OVERVIEW: Working with the PREA Administrator and the Facility Director the following CAP was developed: (1) The Ridgeview Facility Administrator and the PREA Administrator should provide a written explanation to this auditor as to why the Ridgeview Staffing Plan was not updated and reviewed in 2018; (2) Update the 2019 Staff Plan to resolve the issues noted above about the new state law allowing residents up to the age of 25 to reside at the facility; and (3) Ensure the appropriate staff review and sign-off on the staffing plan. The facility entered into the Corrective Action Plan Period on December 30, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all three of the CAP items by providing an explanation of why the Staffing Plan was not updated in 2018, provided an updated 2019 Staffing Plan that took into account the change in possible resident age groups, and provided a copy of a duly signed and executed Staffing Plan. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	REQUIREMENTS: 115.315: This standard has six components: (a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, 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; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) JR policies; 2) the Pre-Audit Questionnaire; 3) Interviews with ten security staff; 3) Review of staff training files; and 4) Interviews with residents (specifically, all nine residents enrolled at the Facility during the audit). OBSERVATIONS: Based on observation, document review, and interviews, the Facility was does not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. The agency does not allow and facility ensures that staff do not conduct cross-gender pat-down searches except in exigent circumstances. The facility does have the forms to document all cross-gender strip searches and cross-gender visual body cavity searches, and the staff would document all cross-gender pat-down searches, however none were reported, thus no forms were used. The facility does implement policies and procedures that enable inmates 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. Further, the policies and procedures do require staff of the opposite gender to announce their presence when entering a residents room or housing area. The facility does not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. The agency does train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

	DETERMINATION: The facility design provides each resident with the ability to shower, perform bodily functions, and change clothing without any staff viewing their breasts, buttocks, or genitalia, except in exigent circumstances. Further, all residents and staff noted that searching a resident to determine their genital status would be a PREA violation and would have to be reported. All staff and residents stated that strip searches are never permitted. Further, all staff and residents were able to state that cross-gender pat searches are not permitted, except in exigent circumstances, and because all staff are trained in how to conduct such a pat-down search in exigent circumstances it was determined that the Facility exceeds this Standard.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.316: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates 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; (b) The agency shall 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 inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.64, or the investigation of the inmate's allegations. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) JR policies; 2) the Pre-Audit Questionnaire; 3) Interviews with ten security staff; 3) Review of staff training files; 4) Review of the training materials used by staff to inform residents about their rights to be free from sexual abuse and sexual harassment; and 5) Interviews with residents (specifically, all nine residents enrolled at the Facility during the audit). OBSERVATIONS: The facility has used training tailored to identify youth with disabilities and to identify the best means to communicate with these youth. The agency maintains a contract for Interpreter Services with an outside service that is utilized as needed. This auditor called this number and interpreter services were immediately available. Further, the facility had on staff certified interpreters. Thus, it was observed that the agency does 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 inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In interviews with security staff all ten reported that they would either access the translation services or secure approval from supervisor to do so. Further, all of the staff reported that they would NOT allow residents to interpret for other residents unless it was an exigent circumstance. DETERMINATION: The facility provides each resident, even those with disabilities (including 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), with 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. The agency provides for and, the facility staff 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, including steps to provide interpreters who can interpret effectively, accurately, and

	impartially, both receptively and expressively, using any necessary specialized vocabulary. This is accomplished by having staff who are trained and certified translators in the predominate languages at the facility. Further, all staff and residents affirmed that staff do not rely on resident interpreters, resident readers, or other types of resident assistants except in limited exigent circumstances. Thus, it was determined that the Facility meets this Standard.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.317: This standard has eight components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who— [(1) 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); (2) 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 (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section]; (b) The agency shall 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 inmates; (c) Before hiring new employees who may have contact with inmates, the agency shall: [(1) Perform a criminal background records check; and (2) 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]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination; and (h) Unless prohibited by law, the agency shall 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) JR policies (5.90 and 1.23); 2) the Pre-Audit Questionnaire; 3) Interviews with HR staff; 3) Review of staff files; 4) Review of contractor files; and 5) Interview with a contractor. OBSERVATIONS: In a review of eight staff files, one contractor file (which represented 100.0% of the contractors at the facility) and interviews with HR staff, found that background checks were performed on all new hires and for staff employed for more than four years. Child abuse registries were checked prior to staff being employed. Further, former institutional employers were contacted. The agency does not hire or promote anyone who may have contact with residents, who— [(1) 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); (2) 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 (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section]. The agency and facility staff do consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents. Before hiring new employees who may have contact with residents, the agency does: [(1) Perform a criminal background records check; and (2) 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]. The agency does conduct criminal background records checks at least every five years of current employees who may have contact with residents. The agency does 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency does also impose upon employees a continuing affirmative duty to disclose any such misconduct. Agency policy notes that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Agency staff noted that unless prohibited by law, the agency would 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.

The only contractor at the facility is a certified teacher employed by the local school district. The school district conducts a background check and consults the applicable child abuse registries and then submits a letter to the facility stating the background checks were performed. The district also ensures that another background check, including the use of fingerprints, is performed every five years.

The However, the agency does not perform a criminal background records check before enlisting the services of any contractor who may have contact with residents. Nor does the facility have in place a procedure for conducting background checks every five years on contractors. Currently, the facility receives a letter from the school district that employs the teacher that a fingerprint background check was performed, and that the teacher passed this background check. Further, the school district ensures that another fingerprint check is performed every five years. However, PREA standard 115.317(d) and agency policy 1.23 requires that the agency perform these checks and not the district. Thus, this component of the standard is not met.

DETERMINATION: It was determined that the agency does not met this standard.

RATIONALE: The agency does not perform a criminal background records check or a review of applicable child abuse registries before enlisting the services of any contractor who may have contact with residents. Nor does the facility have in place a procedure for conducting background checks every five years on contractors. Currently, the facility relies on the school district that employs the teacher to conduct such checks. However, PREA standard 115.317(d) and agency policy 1.23 requires that the agency perform these checks and not the district. Thus, this component of the standard is not met.

	CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility Administrator the following CAP was developed: (1) Update PREA policy and procedure to ensure that DCYF conducts a fingerprint background check and check applicable child abuse registries, compliant with the PREA standards, on all contractors; (2) DCYF shall perform a fingerprint background check on all contractors at the facility; and (3) Submit evidence that the fingerprint background check for the contractors at the facility have been performed. The facility entered into the Corrective Action Plan Period on December 30, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all three of the CAP items. Specifically, the DCYF was able to install a process where all contractors from the local school district are subject to a criminal background check that utilizes fingerprints and is run against a national database. The agency has begun to utilize a company, IndentoGO, that specializes in collecting, processing, and distributing results for agencies requiring fingerprint background checks. Based on the information provided and the requirement that teachers and other school personnel assigned to DCYF facilities, must complete this check before beginning any work at the facilities, it is determined the agency meets this standard. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	REQUIREMENTS: 115.318: This standard has two components: (a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse; and (b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the Pre-Audit Questionnaire, a facility tour, and interviews with staff (specifically, the Agency Head designee, Facility Superintendent, and the Facility's staff and residents). OBSERVATIONS: Though there have been no significant structural changes to the facility since the last PREA audit the facility has significantly upgraded their video monitoring technology. During the updating of the video monitoring system the agency and facility staff significantly improved the quality of the video security system and the number of cameras added. The staff had previously identified blind spots and these blind spots were removed with the intentional placement of additional security cameras. Further, observation of the system and interviews with staff and residents confirmed that no cameras were placed or had an angle that permitted viewing into areas where residents could be showering, changing clothes or performing bodily functions. DETERMINATION: Based on the Agency and Facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the Facility tour and the staff and resident interviews), it was determined that the Facility exceeds this standard.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.321: This standard has eight components: (a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions; (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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; (c) The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary 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; (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. 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. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services; (e) 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; (f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section; (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: [(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.] (h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, (3) Interviews with the PREA Administrator, (4) Interviews with the JR Investigator, (5) Interviews with the PREA Compliance Manager (PCM); (6) Interviews with the

	local hospital staff that employs SAFE or SANE nurses; and (7) Interviews with local area victim services programs. OBSERVATIONS: The agency is not responsible for investigating allegations of sexual abuse as all sexual abuse investigations would be immediately referred to the agency with the legal authority to conduct such an investigation (law enforcement and/or Child Protective Services). The agency has requested that law enforcement (local police departments, sheriff's departments and Washington State Patrol) and Child Protective Services (CPS) follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Facility staff have requested that these investigating agencies utilize a protocol that is developmentally appropriate for youth and, as appropriate, shall be 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. Documented evidence and interviews with local victim advocacy groups supported the fact that facility staff would offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations would be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. The facility has made arrangements to make available to the victim a victim advocate from a rape crisis center. Interviews with this agency supported the fact a trained advocate would be made available 24 hours a day, seven days a week. If requested by the victim, the victim advocate would be allowed to accompany and support the victim through the forensic medical examination process and investigatory interviews and would provide emotional support, crisis intervention, information, and referrals. There is documentation that local law enforcement and/or local hospitals whose staff may perform a forensic exam were asked to utilize 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. Currently, the hospital that has the SANE nurses utilize a protocol that was developed in 2014. DETERMINATION: It was determined that the Facility does meet this Standard.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.322: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) The agency shall have in place a policy 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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals; (c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity; (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations; (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policies and Procedures (5.90 and 1.22), (3) Review of the Coordinated Response Plan; (4) Interviews with staff (specifically, the Facility Superintendent and the Agency investigator); (5) Copies of completed investigations, and (6) the Agency website. OBSERVATIONS: The Agency and Facility do have policies that all allegations of sexual abuse and sexual harassment would be investigated. It is the policy and practice of the agency and facility to refer all allegations of sexual abuse and sexual harassment to an agency with the legal authority to conduct criminal investigations (e.g., law enforcement and Child Protective Services). If these agencies determine that the allegation does not involve potentially criminal behavior, then the JR investigation staff would be responsible for conducting an administrative investigation. The facility does document all referrals of sexual abuse and sexual harassment allegations to the appropriate agency. The Agency's policies describe the responsibilities of both the agency and the investigating entity. It was noted that Policy 1.22 notes that "appointing authorities will refer investigations to DSHS Human Resources Division consistent with DSHS Policy 18.69, Delegation of Authority for Civil Rights Investigations." DETERMINATION: It was determined that the Facility does not meet this Standard. RATIONALE: As JR is now under DCFY policy 1.22 should be updated to reflect the appropriate HR Division as interviews noted that DSHS would not appoint investigators for DCYF. Further, in several areas of the 1.22 policy, references are made to DSHS staff and procedures, these should be reviewed and updated as appropriate. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility Administrator the following CAP was developed: (1) Update PREA policy 1.22 and

	procedures to remove DSHS in appropriate areas; (2) Identify who in DCYF will conduct investigations related to HR; and (3) Submit updated and approved policies and procedures to this auditor. The facility entered into the Corrective Action Plan Period on December 30, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan Period (CAPP), DCFY was able to update the following policies: 1. Policy 2.10, effective dates 8/15/2017 with the technical edits mentioned in this CAP. The Technical Edits were made on 11/7/2019. 2. Policy 2.50, effective date 8/1/2019. Though no technical edit date was noted, the policy did contain the requested updates. 3. Policy 4.30, effective date of 7/18/2019 with the technical edits being made on 10/10/2019. 4. Policy 5.50, effective date of 11/1/2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all four CAP items. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.331: This standard has four components: (a) The agency shall train all employees who may have contact with residents on 11 required topics; (b) Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa; (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policies and procedures, (3) interviews with staff, (4) Training forms, and (5) Training curricula. OBSERVATIONS: All ten of the security staff interviewed noted that they did receive all the required PREA training. All staff interviews noted they felt they receive training that was specific to the "unique needs and attributes and gender of the residents at the Facility." In a review of staff files, it was apparent that staff received the required PREA training prior to having contact with residents. Further, interviews with new staff noted that they received the required PREA training prior to first contact with residents. JR provides two types of training, an Instructor Led Training (ILT) and an online version. In a review of the training files all 10 security staff files reviewed showed that staff completed an online PREA training in the past 12-months using the agency's online training system. The more intensive PREA training was completed via Instructor Led Training (ILT). Staff completing the ILTs are required to sign a form attesting that they attended and understood the training. However, most of the recent training was completed via the online training system. A review of the material found that it was considered to meet standard. For staff taking training via the online system, each staff member is provided a unique name and password. Staff cannot complete the training without having to attest that they attended and understood the training. As each staff member completing online training must note that they attended and understood the training, it was determined that the agency does document via electronic verification, that employees understood the training they received. Further, for some training, the staff are also required to pass a test to ensure that the staff understood the training. This was in addition to the require electronic verification that they attended and understood the training.

	DETERMINATION: Because there is an ability for staff to provide a signature for ILT classes and a means to capture electronic verification that staff attended and understood the training received via the online system, it was determined that the agency does meet this standard.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.332: This standard has three components: (a) The agency shall ensure 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; (b) 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, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policies and procedures, (3) Interviews with staff, (4) Training forms, (5) Training curricula, (6) Interviews with Contractor, and (7) Interview with a volunteer. OBSERVATIONS: The agency provides access to training for all volunteers and contractors prior to their first contact with a residents. The training included their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The level of training and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents are notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Further, the agency does maintain documentation confirming that volunteers and contractors understood the training they received. DETERMINATION: It was determined that the agency met this standard.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.333: This standard has six components: (a) During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment; (b) 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; (c) Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall 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; (d) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills; (e) The agency shall maintain documentation of resident participation in these education sessions; and (f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policies and procedures, (3) interviews with residents, (4) Training forms, (5) Training curricula, and (6) A review of 24 resident files (both current and former residents). OBSERVATIONS: A review of seven current residents' files and 14 former resident files it was found two out of the 24, or 8.3%, did not maintain documentation of resident participation in these education sessions and in one case, 4.2%, the resident received the information beyond the required timeframe mandated by the PREA standards. DETERMINATION: It was determined that the Facility does not meet this Standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility Administrator the following CAP was developed: (1) Review and update as needed the policies and procedures related to how to document resident intake information and PREA education; (2) Training staff, as needed, on the reviewed and updated policies and procedures, (3) Submit evidence that staff attended and understood this training to the Auditor; (4) Six weeks after receipt of the documentation that staff attended and understood the training the Auditor will conduct a desk audit review by asking for documentation of resident training for all residents entering the facility since the staff received their training. The facility entered into the Corrective Action Plan Period on December 30, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all four CAP items by providing additional, and documented, training for staff and completed a Desk Audit.

	FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.334: This standard has four components: (a) In addition to the general training provided to all employees pursuant to § 115.331, 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; (b) Specialized 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; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations. In addition, the following variation in the standard is noted for Juvenile Facilities. The variation is it specifically requires that investigators receive specialized training that includes techniques for interviewing juvenile sexual abuse victims. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) PREA Policy 5.90 and JR Policy 1.22, (3) interviews with Agency and Facility investigators, and (4) Training forms. OBSERVATIONS: Agency provided evidence that all investigators had completed the required PREA trainings related to investigations. Further, the agency provided documentation that the JR investigators were trained in techniques for interviewing juvenile sexual abuse victims. Further, each investigator took additional training related to investigations and each investigator has conducted over a dozen investigations. DETERMINATION: Though it is a best practice to have an independent group of investigators available to complete all investigations it was determined that the Facility does meet this Standard as the agency has trained and experienced investigators who ensure that all allegations of sexual abuse and sexual harassment are investigated.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.335: This standard has four components: (a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in [(1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere; and (d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.331 or for contractors and volunteers under §115.332, depending upon the practitioner's status at the agency. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policies and procedures, (3) Interviews with staff, and (4) Interviews with residents. OBSERVATIONS: Interviews with the administrative staff and with residents confirmed that there are no full-time nor part-time medical or mental health care practitioners who work regularly in the Facility. DETERMINATION: Based on the Agency and Facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the Facility tour and the staff and resident interviews), it was determined that this Standard is not applicable to the Facility.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.341: This standard has five components: (a) Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident; (b) Such assessments shall be conducted using an objective screening instrument; (c) At a minimum, the agency shall attempt to ascertain 11 pieces of required information (see standard); (d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files; and (e) The agency shall implement 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policy and procedures (5.90 and 3.20 [signed 5/20/2019]), (3) interviews with staff (specifically, counseling staff responsible for assessing risk), (4) the Sexually Aggressive or Vulnerable Youth (SAVY) form; (5) Sexual Orientation Gender Identity Screen (SOGIE), and (6) A review of 23 resident files (both current and former residents). OBSERVATIONS: This auditor reviewed related policies and procedures, reviewed 23 resident records including former resident files, interviewed facility staff responsible for conducting a risk screening and interviewed all residents at the facility at the time of the PREA audit. Based on these efforts it was determined that the facility failed to complete the risk assessment, called a SAVY, within 72 hours of the resident's arrival at the facility for two out of 23 youth, or 8.7% of all youth. Further, two youth, out of the 23 youth records reviewed, failed to receive a periodic reassessment per PREA standards and DCYF's Policy 3.20, subsection 3.3. Interviews noted and confirmed that information obtained from the SAVY, along with the resident's historical files, personal history and behavior are used to reduce the risk of sexual abuse by or upon a resident. The assessment is conducted using an objective screening instrument that includes 10 of the 11 pieces of required information per this PREA standard. The information is ascertained through conversations with the resident during the intake process and via medical and mental health screenings and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. The facility has 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. The facility is does consider whether "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" by utilizing another assessment called the Sexual Orientation Gender Identity Screen (SOGIE). Staff interviews confirmed that staff use the results of the SAVY and SOGIE and other methods to place residents in rooms and is

	reviewed prior to placement in rooms with other residents. DETERMINATION: As several residents did not receive their SAVY within the required 72-hours and some youth did not have a periodic reassessment, it was determined that the Facility does not meet this Standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility Administrator the following CAP was developed: (1) Review and update as needed the policies and procedures related to DCYF policy 3.20 to ensure that a risk assessment is conducted within 72-hours of admission; (2) Review and update as needed the policies and procedures related to DCYF policy 3.20 to ensure that a risk assessment is periodically redone; (3) Training staff, as needed, on the reviewed and updated policies and procedures, (4) Submit evidence that staff attended and understood this training to the Auditor; (5) Six weeks after receipt of the documentation that staff attended and understood the training the Auditor will conduct a desk audit review by asking for documentation of resident risk assessments being performed on all residents entering the facility since the staff received their training and for all youth who should have had a periodic reassessment. The facility entered into the Corrective Action Plan Period on December 30, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all five CAP items. Specifically, the facility reviewed and documented training for staff related to the policies and procedures related to risk screenings, including DCYF's policy 3.20, and the facility successfully completed a Desk Audit. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.342	Placement of residents
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	REQUIREMENTS: 115.342: This standard has nine components: (a) The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse; (b) Residents may be 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. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive; (d) 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 shall consider 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; (e) Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident; (f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration; (g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (h) If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: [(1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged]; and (i) Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and facility policy and procedures (5.90 and 3.20 [signed 5/20/2019]), (3) interviews with staff (specifically, counseling staff responsible for assessing risk), (4) the Sexually Aggressive or Vulnerable Youth (SAVY) form; (5) Sexual Orientation Gender Identity Screen (SOGIE), and (6) A review of 23 resident files (both current and former residents). OBSERVATIONS: Interviews with staff and residents affirmed that the agency does use all information obtained pursuant to § 115.341 to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Staff interviews did note that staff would do whatever is required to keep residents staff, including having never leaving them alone, all staff affirmed that isolation of a resident would not be done except in an extreme exigent circumstance and that any isolation would last only minutes, if at all. Staff and resident interviews also affirmed that Lesbian, gay, bisexual, transgender, or intersex residents are not be placed in particular housing, bed, or

	other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Interviews with transgender youth and staff confirmed that when making housing and programming assignments, the agency does consider 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. It was further determined via case file reviews and interviews that placement and programming assignments for each transgender or intersex resident is reassessed at least twice each year to review any threats to safety experienced by the resident. Further, interviews with residents, including transgender residents, noted that their own views with respect to his or her own safety is given serious consideration. Interviews and a tour of the facility affirmed that each resident in the facility can shower separately from other residents. Though some facility staff did not know if a transgender or intersex resident had been in the facility, each staff interviewed recognized that there were no areas of the facility designated as housing areas for these residents. DETERMINATION: It was determined that the Facility exceeds this Standard.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.351: This standard has five components: (a) The agency shall 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; (b) The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; (d) The facility shall provide residents with access to tools necessary to make a written report; and (e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) Interviews with residents, (4) Interviews with staff, (5) Access to the phone system to make a call to an outside agency; (6) Review of allegations and investigations of those allegations; and (7) Tour of facility. OBSERVATIONS: All staff and residents were able to identify multiple internal ways for a youth to report privately to facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such incidents. All the interviewed residents noted that they would tell a staff member, use the posted phone numbers and/or report to their parent or guardians and/or lawyer. Posters with the hotline numbers were observed posted in each residential unit at Facility. A test of the End Harm hotline noted that the call was answered immediately and by a “live” person. Further, it was found that a “live” person answered the phone 24/7 and that the proper authorities in the agency and facility would be immediately notified. Further, it was determined that a resident calling this number could remain anonymous if they so choose. As for residents detained solely for civil immigration purposes, this practice is not allowed interviews with agency staff and interviews with facility staff. All staff, who were interviewed, acknowledged that they must report all verbal reports, anonymous reports, written reports, and reports from third parties regarding allegations of sexual abuse and sexual harassment.” However, the agency does not provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Currently, the agency utilizes Child Protective Services to meet this standard, as per the Pre-Audit Questionnaire and via staff interviews. However, Child Protective Services is part of the Agency as Child Protective Services is under DCYF, just as JR is.

	DETERMINATION: It was determined that the Facility does not meet the requirements for this Standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility's PCM the following CAP was developed: (1) Identify the public or private entity or office that is not part of the agency that has agreed to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request; (2) Submit revised and approved agency and facility policies as appropriate; (3) Submit photographic evidence that notices are posted in the facility that notify residents how to access this public or private entity; (3) Train staff about the new process and submit evidence to this auditor that staff attended and understood the training; (4) Train residents about the new process and submit evidence to this auditor that residents attended and understood the training, and (5) DESK AUDIT: Within six weeks after receipt of the documentation that staff and residents attended and understood the training the Auditor will test the notification process to ensure that a public or private entity or office that is not part of the agency is providing this service AND that this public or private office is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. The facility entered the Corrective Action Plan Period on December 5, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all CAP items. Specifically, as JR was determined to be the "agency" responsible for the confinement of juvenile residents then Child Protective Services (CPS), is a separate agency responsible for the welfare of all children in the state. Thus, having CPS' 'hotline' phone number as "one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request" is determined to satisfy this standard. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.352: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse; (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse; (b)(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse; (b)(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired; (c) The agency shall ensure that [(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint]; (d)(1) The agency shall 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; (d)(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal; (d)(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made; (d)(4) 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, the resident may consider the absence of a response to be a denial at that level; (e)(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents; (e)(2) 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; (e)(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision; (e)(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf; (f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; (f)(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance; and (g) The agency may discipline a resident for filing a grievance related to

	alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures (5.90 and 2.10), (3) Interviews with Agency Staff, including the Agency Head designee, (4) Interviews with facility staff, and (5) Review of civil lawsuits against the agency. OBSERVATIONS: Based on interviews with staff and a review of current litigation cases, it was affirmed that there are no limitations. Specifically, the agency does impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse and the agency does not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. The agency has established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse via a verbal or written request. After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency does 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, and does provide an initial response within minutes. Further, it was determined, via interviews, that a final agency decision would be issued within 5 calendar days, if not substantially sooner. The initial response and final agency decision would document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. Further, Policy 2.10, subsection 15, notes that the agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith. DETERMINATION: It was determined that the Facility does meet this Standard as the Standard is not applicable.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.353: This standard has four components: (a) The facility shall 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, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible; (b) The facility shall 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; (c) The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements; and (d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures (5.90 and 2.10), (3) Interviews with Agency Staff, including the Agency Head designee, (4) Interviews with facility staff, and (5) Interviews with community-based hospitals and victim advocate agencies. OBSERVATIONS: The Facility provided contact phone numbers and addresses to the local hospital and a local victim services agency. Interviews with the hospital and victim services agency noted that services are available 24/7 and that a trained victim advocate would be available to assist the resident. Further, it was determined via interviews that communications with these agencies and services would not be monitored. All interviews (staff and residents) confirmed and acknowledged that residents are provided with reasonable access to parents or legal guardians and that all residents are provided reasonable and confidential access to their attorneys or other legal representative. DETERMINATION: It was determined that the Facility does meet this Standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.354: This standard has one component: (a) The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures (5.90, 5.91, and 2.10), (3) Interviews with Agency Staff, including the Agency Head designee, (4) Interviews with facility staff, and (5) Interviews with residents. OBSERVATIONS: This Facility has multiple means of receiving third-party reports, including phone calls to resident's attorneys and via the End Harm hotline. A test of this system was conducted, and a response was forthcoming. Further, the Facility's website has a process for families to report sexual abuse and sexual harassment via email. Based on interviews with staff, it was determined that a link on the DCYF website would allow a person to make a third-party report. This auditor found this list and attempted to test the email system. However, all attempts were denied. It appears that the list contains invalid email addresses as the email addresses use the old DSHS address rather than the new DCYF email addresses. Further, in a review of the agency's policies and procedures, specifically 5.90 and 5.91, was found to contain references to DSHS Administrative Policies that are no longer applicable as JR is now under the auspices of DCYF. DETERMINATION: As the email system addresses used to, at least partially meet this standard, are not correct and the emails are being rejected, the agency does not meet this standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility's PCM the following CAP was developed: (1) Review and update as needed policy 5.90 and 5.91 to ensure it includes the correct supervising authority for JR; (2) Review and update as needed the email information on the DCYF website; (3) Test the system to ensure the emails are functioning; (4) Send the updated and approved 5.91 to this auditor, and (5) Notify this auditor when the email reporting system is fixed so that this auditor can retest the system. The facility entered the Corrective Action Plan Period on December 5, 2019. CORRECTIVE ACTION PLAN PERIOD (CAPP): On November 14, 2019 at approximately 11:15 AM CST, this auditor received an email from the PREA Administrator that the email system was working, and all email links were updated. On November 14, 2019 at 1:15 PM CST, this auditor tested the system by sending an email to the PREA Compliance Manager for Ridgeview using Microsoft Outlook. The test of this system still showed an error. This auditor tried again, on November 18, 2019, using GMAIL, and the email was delivered, and a response was received from the PREA Compliance Manager at Ridgeview and from the PREA Administrator with DCYF within minutes. Thus, as of November 18, 2019, only the revision to JR Policy 5.90 and 5.91 remain from the Corrective Action Plan. On November 25, 2019, this

	Auditor received a revised and updated Policy 5.91. Thus, all action items for this Corrective Action Plan was completed prior to the publishing of the Interim Report. FINAL DETERMINATION: It was determined that the Agency does meet this Standard.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.361: This standard has six components: (a) The agency shall 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; 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 retaliation; (b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws; (c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be 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; (d)(1) Medical and mental health practitioners shall be 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; (d)(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality; (e)(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall 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 the parents or legal guardians should not be notified; (e)(2) 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 the parents or legal guardians; (e)(3) 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; and (f) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) Interviews with residents, and (4) Interviews with staff. OBSERVATIONS: Staff interviews of 10 security staff and two additional staff revealed that 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 in the facility, whether or not it is part of the agency; 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 retaliation. Resident interviews affirmed that staff always report any allegations. Policy requires and staff interviews affirmed, that staff report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the designated investigators (law enforcement, Child Protective Services, and to agency investigators). All staff noted that they were mandatory reporters and contractors and volunteers also noted that they understood they were mandatory reporters. In a recent sexual abuse allegation, evidence was found that the report was filed within minutes

	of the allegation and that family and the child's caseworker were informed within hours of the filing of the report. As the facility does not employ or contract with mental health providers or medical staff to perform services at the facility, 115.361(d) was considered not applicable. DETERMINATION: It was determined that the Facility does meet this Standard.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.362: This standard has one component: (a) 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) Interviews with residents, and (4) Interviews with staff. OBSERVATIONS: During interviews all staff noted that they would act immediately to protect a resident who was subject to a substantial risk of imminent sexual abuse. Further, all interviewed residents noted that they would “tell staff” if they felt they were at a substantial risk of imminent sexual abuse and each stated they felt the staff would protect them. Further, each staff and the contractor were able to articulate the steps they would utilize to keep the resident safe, including separating the resident from the alleged abuser or potential abuser and ensuring that a trusted staff member was with the resident until the appropriate authorities were notified and responded. DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.363: This standard has four components: (a) 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; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) Interviews with residents, (4) Interviews with facility staff, including the Facility Head, and (5) Interviews with the Agency Head's designee. OBSERVATIONS: Interviews with the Facility Head and staff, specifically intake staff and security staff, noted that the staff would immediately report an allegation that a resident was sexually abused while confined at another facility. Further, the Facility Head noted they would 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. In interviews, it was determined that the Facility Head would make such a report within hours of the allegation but no later than 72-hours after receiving the allegation. Interviews with the Agency Head and the Facility Head noted that the agency would, and does, document that it has provided such notification. Further, the Facility Head noted they would ensure that the allegation is investigated in accordance with these standards. DETERMINATION: It was determined that the Facility does meet this Standard.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.364: This standard has two components: (a) Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to: [(1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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]; and (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) Review of training curricula, and (4) Interviews with facility security staff. OBSERVATIONS: Review of training materials and interviews with staff confirmed that all security staff understood their role as it related to being a first responder. Specifically, each staff was able to note that they would, upon learning of an allegation that a resident was sexually abused, separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and if the abuse occurred within a time period that still allows for the collection of physical evidence, 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; and if the abuse occurred within a time period that still allows for the collection of physical evidence, 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. Staff also noted that they would immediately notify the appropriate facility administrative staff to begin securing video evidence. The contractor, who would not be considered a first responder, noted that they are required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff . DETERMINATION: It was determined that the Facility does meet this Standard.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.365: This standard has one component: (a) 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) Agency and Facility policies and procedures, (3) RCF Coordinated Response Plan , (4) Interviews with staff, and (5) Interviews with the Facility Head. OBSERVATIONS: The facility presented its Coordinated Response Plan and the plan addressed all areas required by the standard. Specifically, the plan detailed the actions to be taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Further, the facility had a Coordinated Response Plan checkoff sheet that could be used by staff as step-by-step instructions on how to respond to an incident of sexual abuse. DETERMINATION: It was determined that the Facility does meet this Standard.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.366: This standard has two components: (a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.] EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire and (2) Interview with the Agency Head's designee. OBSERVATIONS: An interview with the DCYF Agency Head designee noted that the agency/state does have a collective bargaining agreement that was completed since August of 2012. However, nothing in the agreement limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Further, the agency head designee noted that the agency can reassign staff to another facility or building that does not have any contact with residents pending a sexual abuse or sexual harassment investigation. DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.367: This standard has six components: (a) The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation; (b) The agency shall employ multiple protection measures, 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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations; (c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; (d) In the case of residents, such monitoring shall also include periodic status checks; (e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation; and (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90 specifically subsection 28, (3) RCF Coordinated Response Plan; (4) Interviews with staff, (5) Interviews with residents; and (6) Review of reports and investigations of sexual abuse/sexual harassment allegations. OBSERVATIONS: JR policy 5.90 subsection 28 specifically addresses this component. However, interviews with staff responsible for retaliation monitoring resulted in some staff being unaware that retaliation monitoring should be provided to 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. Specifically, a review of an allegation of sexual abuse was reported by a resident. However, this resident was not provided retaliation monitoring. DETERMINATION: It was determined that the Facility does not meet this Standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility Administrator the following CAP was developed: (1) The PREA Administrator will provide refresher training to facility staff responsible for conducting retaliation monitoring, specifically related to who should be provided retaliation monitoring; and (2) Submit to this auditor that the staff attended and understood this training.

	CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address all three CAP items. Specifically, the facility staff responsible for retaliation monitoring were provided a refresher training, and documented this same training, on who should be provided retaliation monitoring and completed a Desk Audit. FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.368: This standard has one component: (a) 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, (3) JR Policy 5.50; (4) Interviews with staff, and (5) Interviews with residents. OBSERVATIONS: All staff interviewed supported the contention that the Facility “never” places a resident in isolation for their own protection against sexual victimization. In a review of the policy (5.50) it was stated that the Facility could place a resident in isolation for short periods of time, not to exceed 15 minutes without reevaluation (subsection 21) and thus is compliant with 115.342. DETERMINATION: As the facility does not utilize segregated housing to protect a resident who is alleged to have suffered sexual abuse it was determined that the Facility does meet this Standard.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.371: This standard has 13 components: (a) 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; (b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334; (c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator; (d) The agency shall not terminate an investigation solely because the source of the allegation recants the allegation; (e) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution; (f) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation; (g) Administrative investigations: [(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) 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]; (h) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible; (i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section 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; (k) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation; (l) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements; and (m) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policies and procedures (1.22, 5.90, 5.91, a document called the Conducting PREA Criminal Investigations), (3) Interviews with staff, (4) Interviews with Agency Investigators, and (5) Review of investigations. OBSERVATIONS: All allegations of potential criminal sexual abuse or sexual harassment are immediately referred to law enforcement and Child Protective Services. The agency only

conducts investigations after law enforcement or Child Protective Services have determined that the allegation does not rise to a criminal level. Based on a review of the data submitted and from interviews with staff and residents, all allegations of sexual abuse and sexual harassment are referred to law enforcement and/or Child Protective Services and these referrals are done promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. The agency and facility have requested that when law enforcement and/or Child Protective Services investigate an allegation alleging sexual abuse, that these agencies use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. Further, interviews with law enforcement noted that their investigators would gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; would interview alleged victims, suspected perpetrators, and witnesses; and would review prior complaints and reports of sexual abuse involving the suspected perpetrator. Agency policy note and interviews with agency and facility staff affirmed that the agency would not terminate an investigation solely because the source of the allegation recants the allegation. Law enforcement and Child Protective Services investigators would, when the quality of evidence appears to support criminal prosecution, conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Agency staff and law enforcement investigators stipulated that the credibility of an alleged victim, suspect, or witness would be assessed on an individual basis and would not be determined by the person's status as resident or staff. Agency and facility staff noted that the use of a polygraph examination or other truth-telling device would not be allowed. For non-criminal administrative investigations the investigators affirmed that their investigations would include an effort to determine whether staff actions or failures to act contributed to the abuse and that all findings would 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]. Law enforcement and Child Protective Services interviews noted that criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and would include copies of all documentary evidence where feasible. Further, these investigators noted that any substantiated allegations of conduct that appears to be criminal would be referred for prosecution. The agency and facility does retain all written reports referenced in this section 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. All interviews noted that the departure of the alleged abuser or victim from the employment or control of the facility or agency would not provide a basis for terminating an investigation. The agency has requested that any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements and when outside agencies investigate sexual abuse, the facility head shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

When the agency conducts its own administrative investigations into allegations of sexual abuse and sexual harassment, it does so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. The agency and facility investigators, who conduct only administrative investigations, after law enforcement or Child Protective Services has ruled out criminal activity, are experienced. As evidence of this contention, the DCYF Agency investigator at each facility was been conducting administrative

	investigations since 2014 and some have been conducting them since 2001. As PREA does not define “experience” in relation to investigators, the fact that each agency and facility investigator have conducted prior investigations, unrelated to PREA, while employed by the Juvenile Rehabilitation (JR) division makes them experienced investigators as defined by PREA. Further, each trained investigator has completed all the required training specified in 115.334, plus the additional requirement articulated in the variance related to juvenile facilities (i.e., that investigators will receive specialized training that includes techniques for interviewing juvenile sexual abuse victims). DETERMINATION: It was determined that the Facility does meet this Standard.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.372: This standard has one component: (a) 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, 5.91 and 2.10, and (3) Interviews with investigators. OBSERVATIONS: Staff noted that they would only use a Standard of “preponderance of evidence” in determining whether allegations of sexual abuse or sexual harassment are substantiated. Further, Agency policy notes that the agency shall use the Standard of preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated DETERMINATION: It was determined that the Facility, in all material ways, meets this Standard.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.373: This standard has six components: (a) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded; (b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident; (c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever [(1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility]; (d) Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: [(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, 5.91 and 2.10, (3) Interviews with facility staff, and (4) Review of sexual abuse and sexual harassment investigations. OBSERVATIONS: Policy 2.10 addresses this Standard and in interviews with staff confirmed they would document these efforts. Further, a review of completed investigations showed that facility staff did updated the resident about the status of their allegation. DETERMINATION: It was determined that the Facility does meet this Standard.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.376: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories; (d) 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, (3) Interviews with PREA Administrator, (4) Interviews with Facility's PCM, (5) Interviews with HR staff; and (6) Review of completed sexual abuse investigations. OBSERVATIONS: JR Policy 5.90 (specifically subsections 5 thru 8) addresses this Standard. Interviews supported the contention that staff would be disciplined for violating the sexual abuse and/or sexual harassment policies. Further, JR Policy 5.90 subsection 7 notes that termination is the presumptive disciplinary sanction. It is noted that JR Policy 5.90, in its current form (effective date 5/20/2019) still includes language the presumes that JR is under the auspices of DSHS. This policy should be updated to reflect the current reality that JR is under DCYF. DETERMINATION: As the policy statements required by this standard are specifically mentioning DSHS (e.g., subsection 6 notes "appointing authorities must immediately institute proceedings to terminate staff who have been found through DSHS or law enforcement investigation, guilty plea or conviction to have engaged in sexual intercourse or sexual contact with a JR youth…"). As DSHS would not investigate a JR staff, as determined via agency interviews, this policy needs to be updated. Thus, it was determined that the Facility does not meet this Standard. CORRECTIVE ACTION PLAN OVERVIEW: Working with the PREA Administrator and the Facility's PCM the following CAP was developed: (1) Revise Agency Policy 5.90, with signature date of 5/20/2019, to ensure it is up-to-date now that JR is under the auspices of DCYF; and (2) Submit the duly approved and authorized revised policies and procedures to this Auditor for review. The facility entered the Corrective Action Plan Period on December 5, 2019. CORRECTIVE ACTION PLAN PERIOD: During the Corrective Action Plan period, the agency was able to address both CAP items by revising agency policy 5.90 and submitted the same to this auditor.

	FINAL DETERMINATION: It was determined that the agency does meet this standard.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.377: This standard has two components: (a) 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; and (b) 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, 1.23, and 1.60, (3) Interviews with PREA Administrator, (4) Interviews with Facility's PCM, (5) Interviews with HR staff; and (6) Review of completed sexual abuse investigations. OBSERVATIONS: Policy 1.60, subsection 14 through 16, related to contractors, specifically address this standard. Staff interviews noted that " any service providers who violate this policy are subject to administrative discipline including termination of employment, criminal sanctions, or both." Further, it was noted that the service providers who violate this policy "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." Interviews with administrative staff noted that they would prohibit further contact with residents, in the case of any violation of agency sexual abuse or sexual harassment policies by a service provider or volunteer and the staff interviewed noted that HR would make contact with the appropriate licensing bodies. Further, facility administrative staff noted that they had the authority to remove any volunteer or contractor from their facility and would do so immediately upon an allegation or suspicion of sexual abuse or sexual harassment. DETERMINATION: It was determined that the Facility does meet this Standard.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.378: This standard has seven components: (a) A resident may 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 or following a criminal finding of guilt for resident-on-resident sexual abuse; (b) Any disciplinary sanctions shall be 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed; (d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education; (e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact; (f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation; and (g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR Policy 5.90, (3) Interview with PREA Administrator, (4) Interview with the PCM, (5) Interviews with security staff, (6) Interviews with residents, and (7) Interview with Facility Head. OBSERVATIONS: It was noted that JR Policy 5.90, specifically subsection 4, deals with this standard. It notes that youth will be disciplined per the appropriate disciplinary code or code of conduct. Based on the pre-onsite visit conference calls with the Facility Head and via the Pre-Audit Questionnaire, and via interviews during the onsite, the Facility would not use isolation for resident-on-resident sexual abuse. Interviews with staff noted that they would consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. After a review of the policies, this auditor could not find any policy that addressed subsection e of this standard. Specifically, that the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact

	DETERMINATION: In interviews a question was raised about sexual abuse of a staff by a resident. It was not an allegation, but a question related to what would happen if a JR resident coerced a staff into a sexual act. This is addressed by the PREA Standard 115.378(e) but no reference to this subsection of the standard could be found in agency or facility policy. However, as every staff member stated that staff would be held accountable for censual sexual acts between a resident and a staff member and not the resident and because the PREA Administrator affirmed that JR "would not discipline the resident if something happened with a staff" that was consensual due to the fact there was an "imbalance of power" between the staff and resident. Thus, it was determined that this standard was met.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.381: This standard has four components: (a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening; (b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening; (c) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law; and (d) Medical and mental health practitioners shall 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR and Facility policies and procedures, specifically 5.90 and 3.20, (3) Interview with the PCM, (4) Interview with Intake Staff, and (5) Interviews with Facility Head. OBSERVATIONS: Staff interviews acknowledge that staff are aware that medical or mental health practitioner must be offered to a youth within 14 days of staff learning that the youth has experienced prior sexual victimization or has perpetrated sexual abuse. Further, in a review of resident files, of residents who reported prior sexual victimization or sexual abuse perpetration, it was found that four had identified being sexual abused and all four were offered a follow-up meeting with a medical or mental health practitioner. One of the four requested such a follow-up visit and it was completed within 14-days of intake. Further, all staff understood, via interviews, that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. DETERMINATION: It was determined that the Facility does meet this Standard.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.382: This standard has four components: (a) Resident victims of sexual abuse shall 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; (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners; (c) Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate; and (d) Treatment services shall 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR and Facility policies and procedures, specifically policies and procedures 5.90, 5.91 and 4.30, and the facility's Coordinated Response Plan, (3) Interview with the PCM, and (4) Interviews with security staff. OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse would be provided with unimpeded access to emergency medical treatment and crisis intervention services. All of interviews (100.0%) with security staff, who are all trained as first responders, confirmed this component and noted that they are trained to protect the victim and to notify a supervisor who will notify the appropriate medical and mental health practitioners. Further, interviews acknowledged that resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate DETERMINATION: It was determined that the Facility does meet this Standard.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.383: This standard has eight components: (a) The facility shall 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; (b) The evaluation and treatment of such victims shall 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; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests; (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (g) Treatment services shall 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; and (h) The facility shall 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. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR and Facility policies and procedures, specifically policies and procedures 5.90, 5.91 and 4.30, and the facility's Coordinated Response Plan, (3) Interview with the PCM, and (4) Interviews with security staff. OBSERVATIONS: Interviews confirmed that the Facility is compliant with this Standard and each component. Staff indicated that they would refer residents to the appropriate contractors (i.e., medical and mental health providers) for any resident who reported past sexual abuse and that these services would include medical and mental health evaluation and follow-up, including transition planning. Further, agency policy 4.30, subsection 65 and 66, specifically addresses this standard. DETERMINATION: It was determined that the Facility does meet this Standard.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.386: This standard has five components: (a) The facility shall 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; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) 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; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Interview with the PCM, (4) Interviews with investigators, (5) Interview with Facility Head, and (6) Review of investigations. OBSERVATIONS: Interviews with staff indicated that the Facility would 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 and that this review would be done within 30-days of the conclusion of the investigation. Policy 5.90, subsection 47, further reinforces the Facility's adherence to this PREA Standard. A review of a sexual abuse investigation confirmed that a sexual abuse incident review was conducted at the conclusion of investigation. DETERMINATION: It was determined that the Facility does meet this Standard.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.387: This standard has six components: (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice; (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents; and (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Survey of Sexual Victimization, (4) Interview with the PCM, (5) Interviews with investigators, (6) Interview with Facility Head, and (7) Interview with the PREA Administrator. OBSERVATIONS: The Facility did produce a Standardized instrument so that it can collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a Standardized instrument and set of definitions. The instrument provided was the SSV. Data from the JR website at https://www.dcyf.wa.gov/practice/practice-improvement/prea notes that aggregated data is presented. An interview with the State of Washington's PREA Administrator, indicated that JR maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The PREA Administrator also noted that the agency, upon request, will provide data from the previous calendar year to the Department of Justice no later than June 30. DETERMINATION: It was determined that the Agency materially meets this Standard.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.388: This standard has four components: (a) The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole]; (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse; (c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means; and (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Survey of Sexual Victimization, (4) Interview with the PCM, (5) Interviews with investigators, (6) Interview with Facility Head, (7) Interview with the PREA Administrator, and (8) Review of the 2018 PREA Report. OBSERVATIONS: An annual report is posted at https://www.dcyf.wa.gov/sites/default/files/pdf/prea/JR%20Annual%20Report%202018%20Signed.pdf. This report addresses corrective actions taken by Facility type. DETERMINATION: It was determined that the Agency materially meets this Standard.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.389: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained; (b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Survey of Sexual Victimization, (4) Interview with the PCM, (5) Interviews with investigators, (6) Interview with Facility Head, (7) Interview with the PREA Administrator, and (8) Review of the 2018 PREA Report. OBSERVATIONS: Interview with the PREA Administrator, indicated that incident-based and aggregated data were securely retained. Data from the JR website at https://www.dcyf.wa.gov/sites/default/files/pdf/prea/JR%20Annual%20Report%202018%20Signed.pdf reveals that aggregated data is presented and this is compliant with Agency policy. Further, interviews with the PREA Administrator indicated that sexual abuse data is collected and maintained for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. DETERMINATION: It was determined that the Agency does meet this Standard.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.401: This standard has six components: (a) During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once.; (b) August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. (c) The auditor shall have access to, and shall observe, all areas of the audited facilities; (d) The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information), (e) The auditor shall be permitted to conduct private interviews with inmates, residents, and detainees, and (f) Inmates, residents, and detainees shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Interviews with residents, (4) Interview with the PCM, (5) Interview with Facility Head, (6) Interview with the PREA Administrator, and (8) Review of documents. OBSERVATIONS: Based on a published list of all facilities audited by year, and with the PREA Audit linked, it was determined that during the three-year period starting on August 20, 2014, and during each three-year period thereafter, the agency has ensured that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. Further, it was determined that since August 20, 2014, the agency has ensured that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. During the audit this auditor did have access to, and did observe, all areas of the audited facility. This auditor was permitted to request and receive copies of any relevant documents (including electronically stored information) and this auditor was permitted to conduct private interviews with inmates, residents, and detainees, and interviews with residents confirmed that they were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. DETERMINATION: It was determined that the Facility, in all material ways, does meet this Standard.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	REQUIREMENTS: 115.403: This standard has two components: (a) The agency shall ensure that the auditor's final report is published on the agency's website if it has one, or is otherwise made readily available to the public, and (b) The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the (1) Pre-Audit Questionnaire, (2) JR policies and procedures, specifically 5.90, (3) Interview with the PCM, (4) Interviews with investigators, (5) Interview with Facility Head, (6) Interview with the PREA Administrator, and (7) Review of the 2018 PREA Report. OBSERVATIONS: Previous audits of all agency facilities were posted at https://www.dcyf.wa.gov/practice/practice-improvement/prea. Previous audit reports, including those pending appeal, are posted. DETERMINATION: It was determined that the Facility materially meets this Standard.

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 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
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	yes

	and determining the need for video monitoring: The number and placement of supervisory staff?	
	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.)	na
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)	na
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	na
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)	na
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	yes

	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?	
	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	yes

	through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	
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.)	na
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 is not responsible for investigating allegations of sexual abuse.)	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?	yes
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?	no
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?	no
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment?	no
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?	no
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.)	no
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?	no
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?	no
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?	no
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.	yes
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.)	na
	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.)	na
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.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na

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.)	na
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na

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.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	na
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	na

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.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
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.)	na

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?	no
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	no

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?	no
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	no

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.)	yes
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.)	yes
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
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes

115.387 (c)	Data collection	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes

115.388 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes

115.401 (b)	Frequency and scope of audits	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	yes
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	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
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes